PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

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Dollars and Cents

*Total Annual Income and Expenses in 97 Non-Official Public Health Nursing Agencies in 1932**

By LOUISE M. TATTERSHALL

Statistician, National Organization for Public Health Nursing

AT last we have two figures we have been longing for—total income and total expenditures of a representative group of public health nursing agencies in the United States. We know our readers will welcome these statistics. How public health nursing agencies are supported and how they spend their money are two interesting questions at any time, but right now, take first place in board and community thinking. Ninety-seven non-official public health nursing associations have sent the N.O.P.H.N. detailed statements of their income and cash expenditures for 1932. These agencies are located in all parts of the country and include more than half of the non-official public health nursing agencies employing 10 or more nurses and about 1/3 of the agencies employing 2 to 9 nurses.

INCOME

The sources of agency income have been classed under 4 headings:

Tax Funds—These include all monies received from governmental bodies, state, county or city, whether in the form of a grant of a definite sum or reimbursements for services rendered to individuals.

Contributions—These include all monies received from the community chest, American Red Cross, Christmas Seal Sale, organization drive for funds, membership dues or gifts.

Interest and Capital Funds Used for Current Expense—These include interest on endowments and other invested funds, and any legacies or capital funds used during the year for the expenses of the agency.

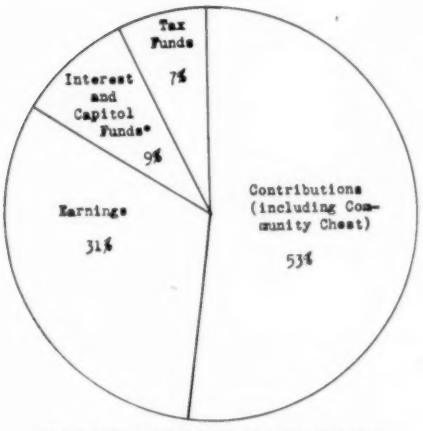
Earnings—These include income from services paid for by patients, insurance companies, employers and others.

As would be expected, the largest source of income in non-official public health nursing agencies is from *Contributions*, which make up 53% or more than one-half of the total income. The next largest source of income is from *Earnings*, which make up 31% or not quite 1/3 of the total income. *Tax Funds* and *Interest and Capital Funds* are each less than 10% of the total income. All agencies, but one, reported having income from *Earnings;* only a little more than half the agencies received income from *Tax Funds*.

*Agencies employing two or more nurses.

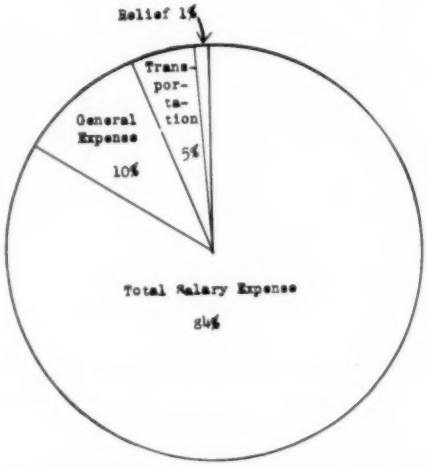
EXPENDITURES

These are the cash expenditures of the agencies and do not include the cash value of donated items. As only 7 of the 93 agencies reporting, state that they received free rent or free transportation, these cash expenditures may be considered representative.



*Capital Funds used for Current Expense.

How non-official public health nursing associations are supported.



How non-official public health nursing associations spend their money.

The total expenditures have been grouped as follows:

Total Salary Expense—This includes all salaries paid nursing staff, office and clerical staff, and special workers.

General Expense—This includes all expenses for housing and carrying on the work of the agency.

Transportation—This includes all expenses for automobiles and carfare.

Relief—This includes money spent for food, clothing, or other financial help to individuals or families.

Not only is the expense for salaries the largest item, but it is more than 4/5 of the total expenditures in the agencies. This brings out very strikingly that the only point at which an appreciable decrease may be made in the costs of public health nursing, is in *service*—either personnel must be reduced in one way or another or the program of service must be curtailed to be carried by fewer staff.

When we consider that among the agencies reporting, the public health nursing program of some of the agencies includes only sickness service and maternity service, while in others are added health supervision service, special programs for tuberculosis, mental hygiene or nutrition, and health conferences or clinics (which means that special workers are employed); that the housing of the agencies varies greatly; and that in some agencies, there is only a very lim-

TABLE 1. CASH EXPENDITURES OF NON-OFFICIAL PUBLIC HEALTH NURSING ASSOCIATIONS, 1932

Size of nursing staff	Number of agencies	Per cent of total expenditures for: All salaries	General expense	Transportation	Relief
All agencies	93	83.5	9.9	5.3	1.2
50 or more nurses	12	84.8	9.2	4.0	1.8
25 to 49 nurses	14	81.9	11.8	5.1	1.0
15 to 24 nurses	13	84.1	8.6	7.0	*
10 to 14 nurses	15	79.8	12.0	8.0	*
6 to 9 nurses	25	82.3	8.9	7.9	.8
2 to 5 nurses	14	80.4	9.1	9.3	1.1

*Less than .5% of a per cent.

ited clerical staff, in others a quite adequate staff, it is very interesting to see (Table 1) that the percentage distribution of total expenditures for the 4 items varies so little in all the agencies with different sized nursing staffs.

In determining the average expense per nurse per year as given in Table 2, the total number of nurses employed (executive, supervisors and field nurses) is used.

TABLE 2. EXPENSES PER NURSE PER YEAR

Size of nursing staff	Number of agencies	Expense per nurse per year for: Expenditures Total	Total Salary Expense	Nursing Salary Expense
All agencies	85	$2270	$1890	$1700
50 or more nurses	11	2330	2000	1810
25 to 49 nurses	11	2230	1810	1570
15 to 24 nurses	12	2100	1770	1600
10 to 14 nurses	15	2250	1800	1600
6 to 9 nurses	23	2160	1780	1600
2 to 5 nurses	13	2300	1870	1640

MORE FACTS ABOUT SALARIES IN AGENCIES EMPLOYING ONE NURSE

What salary does the nurse, who is the only public health nurse on the staff of an agency, receive? This can be answered from information received by the National Organization for Public Health Nursing in 1933 from 400 agencies located in various states, which employ but one nurse. These agencies represent approximately 25 per cent of all agencies employing one nurse, both official and non-official, exclusive of boards of education and life insurance company services.

The median monthly salary paid by all the agencies reporting is $125.00, $125.00 for official agencies, and $135.00 for non-official agencies. Fifteen per cent of all agencies reporting state that no reduction was made in the monthly salary during 1932 or January, 1933. Eleven per cent of the official agencies and 26 per cent of the non-official agencies report no reduction in salaries. The median per cent reduction of those agencies making cuts is 15 per cent for all agencies reporting, 16 per cent for official agencies, and 13 per cent for non-official agencies.

Our readers will be delighted to know that "Public Health Nursing in Industry" prepared by Mrs. Violet H. Hodgson for the National Organization for Public Health Nursing, has gone to press and will be published this month. Details regarding the ordering of this book may be found in the advertising pages of this number of the magazine.

There has been enthusiastic reception of the year's trial of a School Health department in the magazine. The editors are glad to announce that the department will be continued and plans are under way to use its pages in 1934 for a school health study program covering the outstanding present-day problems of school nursing. The study program will include discussion by authorities and reference reading.

Practicing Preaching in the High Sierras

Would you—a public health nurse—like the experience of bringing up your infant son at a gold mine, 7400 feet above sea level and 12 miles from the nearest store? This is Mrs. Bachels' story—

By ISABEL GLOVER BACHELS, R.N.

FOUR HILLS MINE is a gold mine with an interesting history and equally interesting possibilities when money enough is available for its necessary development. It is located above the lake country at the upper end of the beautiful Feather River Canyon on the ridge between Plumas and Sierra Counties in California, at an altitude of 7,400 feet. The country is rich in stories of Gold Rush days and "lost mines", and abounds in "ghost towns" —some of them so ghostly that only a name remains. Our post office, Johnsville, 2,000 feet lower and six miles distant by trail or ten by road, was once a lively mining town but now cannot boast even a store. Blairsden, six miles farther and on the Western Pacific railroad, has the nearest store; Portola, twenty miles beyond, the nearest hospital, doctor or dentist. To reach a specialist of any kind one must go still another fifty miles to Reno, Nevada.

In the opposite direction, Downieville, the county seat of Sierra County and one of the very interesting old towns, sixteen miles distant and 4,500 feet lower, is reached from here only by trail.

Residence at Four Hills Mine. Winter view from hill just above the house.

The house in which my husband and I live, although dilapidated-looking as is usual in old mining camps, is comfortable and not too unattractive. There are three bedrooms and bathroom upstairs; downstairs a big sunny living room with a stove that burns four foot logs, and a large kitchen with sink, stationary tubs and water power washing machine. Our water supply comes from two springs, one about two and a half miles distant, the other about a

mile—wonderful mountain water, cold as ice, soft as rain water, and free from any chance of contamination.

As a public health nurse, mountain roads were no novelty to me, but my first trip up here made a lasting impression. The lower part of the road leads through a wooded canyon. The first ten to twenty feet of the tree trunks are bare of moss because of the deep winter snow, the smaller trees with branches below snow-line are bent down and twisted. Higher up the trees are smaller and more scattered, those on the ridges show the battle scars of many winters—the windward side bare of branches and the bark scoured smooth by sleet and sand. There are lovely views of several of the lakes. On skis one can go by way of Wade's Lake, where there is a drop of perhaps a thousand feet in half a mile from the top of the ridge above the mine to the lake.

There is seldom enough work during the winter to justify keeping a crew at Four Hills Mine. It is a man's country. Only twice in my three winters has a woman come up between November and June. The only two within hailing distance even in summer, except when we have had guests, have been the wives of miners who cooked at the boarding house in summer. I had never stopped to think, until the boarding house burned down this winter, how much faith man puts in a few sticks and stones. With the boarding house gone, there would be not so much as a stove, a bed, or a bite to eat within five miles—and that not an ordinary five miles, but one that would require still further dependence on slender pieces of wood, for travel without skis or snow shoes is all but impossible many months in the year.

Only once have I feared the snow and isolation. Shortly before Christmas in 1931 a man who was to bring up the mail and a few supplies from Johnsville was lost and Mr. Bachels and his brother started at night to search for him and were gone hours—finally missing him. My frantic telephone call reached the Jamison, a mine just above Johnsville, just as the rescuers were starting to follow his track up an old and fatally dangerous trail.

Residence at Four Hills Mine. The same view in summer.

That winter was the hardest in at least ten years—almost continuous storms from November until February. Several times the snow piled up to a depth of almost twenty feet on the level, much more, of course in the drifts. The windows on the down-hill side of the

house were covered half way up the upper panes, so that for weeks at a time the view from indoors was limited to patches of sky and a few tree tops. Storms were so continuous that most of the time travel even on skis or snowshoes was impossible. Each trip out meant real danger, especially after the 'phone line went out of commission. We received mail once in three weeks from early November until April. Our only link with the outside world was the radio, which we had to use sparingly lest the batteries give out.

My only trip out that winter was the last of March when we went to San Francisco that I might be examined to see if our hopes had been realized and if they had, to make arrangements for my confinement. I had sent for the necessary equipment for making urinalysis and had begun following Maternity Center routine since early in January, keeping a record to take with me when I went for my examination. As soon as we could keep the horses here, I had to ride enough to be in condition to make the trip out on horseback in case the road was not open. However, the snow melted and the first car came in the last week in July, giving me several weeks margin.

In San Francisco the Personal Service Department of the Y. W. C. A. helped me find very satisfactory housekeeping rooms not far from the hospital. I had dreaded the waiting but it proved a real vacation. Relatives from southern California planned their vacation trips to visit me and we had a delightful time. Care at Children's Hospital was all that could be desired and my doctor was wonderful—one chosen from the list given me by Miss Deutsch, Director of the San Francisco Visiting Nurse Association. Mr. Bachels waited until my second week in the hospital to come down as he could stay only a few days.

After two weeks in the hospital it was not too difficult to care for myself and the baby in the pleasant rooms I had, although I was glad I did not have to learn how to care for a new baby for the first time. Because of the difficult trip up to the mine and the fact that, once there, I would be out of reach of medical care, I stayed in the city until after my six weeks' postpartum examination. Everything was all right.

This winter has been easy—no trips when there was real danger, snow not more than ten feet at any time and no severe storms, although now, in May, it is still snowing. Recently, the snow has been hard enough to walk without snowshoes, and to take baby out on the sled his father made.

The first chance he had to know that the world contained more than three persons besides himself, came the last of February when seven men arrived late one afternoon—a rescuing party *and* the rescued. With the boarding house gone, there were not beds enough for so many. They did not mind sleeping on our couch and floor in the living room. I must remark that having a crowd of men descend unexpectedly upon one is not the ordeal here that it might be in many places, for all the men help about the house as a matter of course. They washed the dishes and got their own breakfast next morning. We have to get in a supply in the Fall sufficient to last six months or more anyway, so instead of going to the corner store, I go to the store room!

Living here requires the kind of ingenuity so valuable to a public health nurse. Mr. Bachels has a generous supply of it! Two years ago we had so little snow that we kept a horse on the place. New Year's morning a storm began. Mr. Bachels took the horse to the top of the ridge and started her down the trail toward the ranch where she usually spends the winter. Just before dusk I thought I heard a horse's bell. There stood Midget waiting to be put into the barn! As we did not have hay enough to keep her all winter, Mr. Bachels feared we might have to shoot her. However, he remembered having seen snow shoes on stage horses years ago, so decided to try to make some for Midget. They were a success and

Midget had no difficulty learning to use them! This spring we are using them on one of the other horses. They make it possible to bring in a horse much earlier than would otherwise be possible.

This winter the long pipe line froze early in December. The other spring is dry in winter. To melt snow for so many months for all household purposes would have been a serious inconvenience, except for Mr. Bachels' improvised water system. He put a tank on the porch roof, where snow could be shoveled in from the hill above the house, with one pipe carrying hot water from the coil in the big stove up to the tank to melt the snow and another to bring back the snow water. So the plumbing has worked as usual—on an economical basis!

Our equipment for taking care of Baby Andrew is largely make-shift, but has proved very satisfactory. The house was built without any thought of babies. Though not ideal, the sunny end of the kitchen was the most desirable place for a nursery. There we have a table with gold scales (exceedingly accurate, but I have to reduce from Troy to Avoirdupois), and other equipment for care, including my "library." The rubber bath tub, when not being used for the purpose for which it was intended, serves as a place for storing clean clothes and for changing the baby. Until he got too active it was a good place for him to kick and have his sun baths. By the time it was no longer safe, Mr. Bachels had made a "kicking board"—a board larger than the top of the tub, with six inch sides sloping outward so as not to shut off the sun. We had never heard of one, but do not see how we would have managed without it. Before he got too lively for that, a play pen had been made to fit on the couch in the corner of the kitchen where it can be moved in front of either window. When the floors are warm enough and more space is needed, the sides will unfold to make a fence across the sunny end of the kitchen or in the living room. The discarded kicking board turned upside down, now makes a platform to raise the nursery chair off the cold floor at "chore time." Both windows, southeast and southwest, can be lowered from the top. Cloth covered screens are used in kitchen and bedroom windows when the wind is too strong to have the windows open. At bedtime and nap-time many steps are saved and a warm bed insured by arranging pad and covers on the tub and carrying the baby upstairs on them.

Midget on snow shoes.

Much as I would appreciate having the chance to talk with a pediatrician, I can assure public health nurses and women living in out-of-the-way places that the advantages to the baby can well offset the inaccessibility of such help as the city offers. Here we have quiet, uninterrupted routine, wonderful sunshine and pure air, complete freedom from contact with communicable diseases, even colds. Andrew, Junior, is now nine months old. He has never had a cold, never had diarrhea or needed a laxative (other than his fruit juice).

It seems to me that looking at prenatal and infant care from the standpoint of the family far from civilization, the one thing I have had that would not be available for women without my training, has been the confi-

dence that I could meet successfully the situations ahead of me. Prenatal and infant care, from the standpoint of both physician and nurse, must necessarily be very different from that in cities. It seems to me that the job of the rural

Andrew Bachels, Jr., age 7 months

nurse is, first of all, to inspire her patients with the confidence that they can meet successfully their problems as they arise, always being ready to recognize the need for more expert help; then, to help arrange for the best obstetrical care that they can afford, making them willing to sacrifice other things for the sake of such care. The nurse can teach them, with the doctor's approval of course, how to do for themselves some of the things that are ordinarily done by a doctor or nurse; she can put within their reach the literature that will provide needed information in a form adapted to the education and mentality—and I might add, time—of each one. With the literature should go an appreciation of the fact that there is no place to which to turn that will tell *exactly* what to do under all circumstances; that what they read will be only the foundation on which to build; that there is no way to escape the necessity for using brain and common sense.

Last but not least there needs to be some way of reaching fathers, either individually or collectively, directly or through the mothers. The women in my mothers' classes when I was doing rural work in Indiana, asked if I could not arrange classes for fathers also. I left the county before we had a chance to try such classes, but I appreciate now even more than I did then what the classes might mean. I do not see how really fine prenatal or child care can be possible without the understanding and coöperation of the father.

GENEROUS GESTURE

Until the present time we have refused permission to individuals to copy or enlarge the figure of the scurrying public health nurse used in this magazine, because it was especially made for us and very precious. However, so many readers have asked for it, and so many others have already copied the figure, that we are regretting our stinginess. We hereby give permission to any subscriber or member of the N.O.P.H.N. to copy or use this figure from the magazine for any *professional* purpose. We would like a credit line for the sake of publicity for the magazine—but we will not insist even on this!—*The Editors.*

The Nurse's Opportunity in Hookworm Disease

By CH. WARDELL STILES

Has hookworm disease been stamped out in the United States? Dr. Stiles, an eminent authority on the subject, emphatically says "No". In the following article he describes the importance of the nurse's rôle in case finding and treatment.

HOOKWORM disease is caused by the presence of a worm (*Necator americanus*, the New World form, and *Ancylostoma duodenale*, the Old World form) in the small intestine. The parasites are hatched from the ova, which are passed from the body in the excreta and which, under favorable conditions of temperature (70°-90°F.) develop into larvae in a few hours to a few days. The larvae become "encapsulated" (within their moulted cuticle) and may reach the intestine through swallowing, or penetrate the human skin, notably of the feet, ultimately getting into the bloodstream, to the lungs, through the air cells and pass via the bronchial tubes and trachea into the alimentary canal. When the larvae penetrate the skin a condition sometimes known as "toe-itch" or "ground-itch" is set up.

Symptoms—Anemia; pallor, dull, listless expression, speech and gait; muscular weakness. In extreme cases, edema, ascites, emaciation and dirt-eating may be present.

The spread of the disease is due to contact with material polluted with fecal matter. The infection may occur among miners, brick and pottery workers, tunnel workers, quarrymen, persons employed in lumber and construction camps, and persons who come in contact with infected soil at work or at home. In the United States, this is a disease chiefly of the rural districts.

Prevention is largely a matter of sanitation. Pollution of the work environment may be prevented by providing adequate sanitary privy facilities. Infected soil and excreta of infected individuals should be properly disposed of (by burial or otherwise) and adequate foot covering and washing facilities available and used. Since the mouth, especially in cool weather, may be a portal of entry of the parasite, emphasis should be placed on the need of washing the hands before eating.

In the great mass of literature on hookworm disease very few articles discuss the rôle which public health nurses can and do play in its recognition and control. In fact, if a reader (not familiar with the practical side of the subject) considers the literature of the past fifteen years, he might easily gain the impression that this infection has been reduced largely to questions of laboratory microscopic work, mathematics and formulae, and that the nurse is practically eliminated from the situation—except possibly that she might be permitted to help in a very secondary manner in connection with the treatment of some cases.

The object of this article is to present a very different point of view as seen through the spectacles of an "old-timer", who after many years' absence from hookworm campaigning has returned to the subject as a "hobby" after retiring from active professional duty.

THE NURSE'S RESPONSIBILITY

The nurse's responsibility may be divided into two categories, namely, that

of the hospital or private duty (or case) nurse (North or South) and that of the rural public health nurse in the South. The nurse doing bedside work, either in the North or the South, has an opportunity to discover unsuspected cases. If she is bathing a southern patient (or one who before puberty has visited the rural South) and notices marked underdevelopment of axillary or pubic pilosity or an unusual or a very prominent scar below the knee, especially on the tibial ridge or on the ankle, she will do well to inquire into the origin and history of the scar and also ask whether the patient recalls having had ground-itch. In anemic southern patients, the pilosity is likely to be much scantier in persons who, before puberty, had hookworm disease than in cases of anemia due to malaria or other causes. I have known of instances in which southern nurses have suspected hookworm infection on this basis and their suspicions been verified by the microscopic examination ordered by the clinician as a result of the nurses' report.

In all cases of irregular menses (especially of the delayed type) in southern patients, hookworm disease should be considered as one of the possibilities and a microscopic examination should be made to confirm or to eliminate this possibility. I have known numerous hookworm cases among southern girls in whom the first period appeared late (say at sixteen, eighteen, and one case even at twenty-seven years of age) and numerous girls who menstruated only three to six times a year. In one series of statistics in a southern county, the rural girls first menstruated, on an average, one year later than the average of the city girls in that same county; the difference was due to hookworm disease.

Thus, for the bedside nurse dealing with southern patients the important clues (in addition to anemia) are: scanty pilosity, tibial scars, delayed menses, and a history of ground-itch.

Few persons are really aware of the important rôle which the rural public health nurses—especially the school nurses—can and do play in uncovering cases of hookworm infection.

In many a southern county public health nurses are connected with the local health unit; some counties without health officers have public health nurses or welfare workers; in some cases the schools employ nurses. These nurses visit the schools or the families and in connection with their work collect samples of fecal material for microscopic examination by the state or county laboratory. They are doing a wonderful work—far greater than the public realizes. I speak with intimate knowledge of their energy, enthusiasm, and faithfulness. It is to be greatly regretted that in the present financial crisis, their work has been cut down to an uneconomical minimum.

SELECTIVE EXAMINATIONS

In the early part of this century, wholesale microscopic examinations were made of all pupils in many southern public schools and of all other persons who applied for the examination. There were sound reasons for adopting this plan, sometimes called "mass examination".

In recent years, some workers have adopted a plan known as "egg-counting" in order to estimate the intensity of infection (namely, number of hookworms present in a given patient), but with secondary, if any, study of symptoms. Whatever may be argued theoretically for or against this method as a public health technique, the practical point exists in the present economic conditions that it is more costly in time and money than is a "selective examination".

"Selective examination" consists in picking out for microscopic study only the children who exhibit certain suggestive symptoms. In some counties this selection is made entirely by the public health nurses, who rapidly become expert and trustworthy in the work, and who are today doing a great public service in this respect. The nurses soon gain the confidence of the school teachers who are in a position to coöperate with the nurses by calling attention to certain pupils.

This plan has the advantage of uncovering more promptly a greater num-

ber of pupils who are more likely to benefit from hookworm treatment, thus doing a greater amount of good with a given expenditure of time and money, than does the plan of "mass examinations".

An objection which might be cited (and in fact is occasionally cited) against the plan of "selective examinations" is that cases of very light infection can be easily overlooked, thus leaving a number of carriers in a community. This objection is likely to be overestimated, for it is financially impracticable (even if it were possible) to examine one hundred per cent of the inhabitants of a county or state. Therefore we must expect to deal with the carrier problem for several generations to come, regardless of whether we adopt the "selective" method or the "mass" method of examination. This carrier problem—as has been recognized for years past—can be handled more easily by improving the sanitation, than by trying to find and to induce all infected persons to submit to treatment, and this improvement in sanitation has the advantage that it decreases various other soil pollution diseases (amoebic dysentery, typhoid, etc.), in addition to hookworm disease. It is wise, however, to advise known carriers to take the treatment.

BASIS FOR SELECTION

As a general basis for a "selective examination" I am advocating that school children be divided by the teachers into five groups, namely:

Group A: "Repeaters", backward children, failing in examinations or otherwise not "keeping step".

Group B: "Puny", anemic, underfed, or undernourished children.

Group C: Girls maturing slowly or irregularly, with partial or complete amenorrhea.

Group D: Children with recent dew-itch or ground-itch, especially during the summer vacation.

Group E: All other pupils.

By far the majority of school children who really need examination and treatment for hookworm disease will be included in Groups A to D; Group E will, of course, include a number of carriers, but relatively few frank patients.

A nurse, trained to recognize symptoms more readily than the teacher, can well adopt these same groups as the basis of her selection, but she is in a position to consider additional points in the children—for instance, complexion—especially yellowish discoloration of the nasal alae, epigastric tenderness upon pressure during deep inspiration, dilated pupils, dry hair, cervical pulsations, constipation. She will do well, however, to recall that under electric light, on rainy or cloudy days, and in rooms with yellow or brownish walls or curtains, her work becomes more difficult in judging the complexion. I prefer to do this type of work on bright days with good sunlight and I usually stand with my back to the window, with the child facing the window.

I advise distinctly against treating the children selected as hookworm "suspects" unless the preliminary and tentative symptomatic diagnosis is definitely confirmed by microscopic examination, especially if carbon tetrachloride is to be administered. In only very rare exceptions and for very special reasons have I personally been willing to treat cases (and then not with carbon tetrachloride) without microscopic confirmation, and I am not a believer in the plan known as "mass" or "herd" treatment. For legal and ethical reasons, the nurse will not, of course, administer treatment except at the direction of a physician.

Carbon tetrachloride should never be used in case the patient has stomach worms (*Ascaris lumbricoides*), as this drug causes the latter to become active and to wander, thus raising the possibility of a fatality.

DIFFICULTIES IN TREATMENT

Few persons except health officers and nurses know the difficulties occasionally encountered in inducing some ignorant parents to consent to having their children treated. Fortunately these instances are not so common as they were from 1902 to 1910. Especially among these reluctant cases the nurse plays an important rôle, for she can talk to the mothers "in their own language" and fre-

quently can accomplish more than the health officer or the physician, as I can testify from personal experience.

In discussing treatment with the parents, the nurse must be prepared to meet a relatively new obstacle which I have met during the past three years since my return to field work in hookworm disease. In 1927, the Rockefeller Foundation announced that "hookworm disease has almost disappeared from the United States." This highly exaggerated statement from such a prominent authority, which has accomplished so much good here and abroad in combatting this malady, was broadcast by the lay press, reached a vast audience, and was accepted as authoritative by many people both in educated and in uneducated circles. As a matter of fact, the claim is not in harmony with theoretical considerations, and is contradicted by actual clinical observation and by laboratory investigation.

The nurse is in a position to help counteract the harm which this claim has done. One is not likely to meet hookworm patients on Broadway, but I know of no health officer in the South who accepts the statement and, in fact, many southern health officers, physicians, nurses and zoologists deny it from actual experience as positively as I do. Any person in a position to compare the conditions of 1902-1908 with conditions today, will enthusiastically admit that hookworm disease has undoubtedly decreased in this country, but if we consider the immensity of the problem involved in changing the habits of hundreds of thousands of rural negroes, Indians and whites, we will conservatively admit that it will take three generations longer to complete the job.

The rural public health nurse is destined to play a big rôle in this work. Let us hope that she will not be unduly handicapped by ill-advised policies of false economy. She is a paying investment to the community.

HOW MANY HAVE YOU?

Total individual N.O.P.H.N. membership by State as of June 30, 1933

	1933	1932		1933	1932
Alabama	35	61	New Hampshire	43	49
Arizona	17	29	New Jersey	322	354
Arkansas	29	57	New Mexico	29	26
California	218	254	New York	1,062	1,244
Colorado	73	78	North Carolina	25	47
Connecticut	285	336	North Dakota	15	19
District of Columbia	95	92	Ohio	284	362
Delaware	23	21	Oklahoma	48	56
Florida	36	37	Oregon	37	47
Georgia	69	91	Pennsylvania	525	607
Idaho	5	10	Rhode Island	192	205
Illinois	273	343	South Carolina	24	31
Indiana	116	176	South Dakota	15	13
Iowa	136	131	Tennessee	137	136
Kansas	84	103	Texas	120	189
Kentucky	99	117	Utah	14	19
Louisiana	29	33	Vermont	25	23
Maine	61	84	Virginia	108	148
Maryland	39	39	Washington	50	58
Massachusetts	431	539	West Virginia	44	64
Michigan	636	720	Wisconsin	133	157
Minnesota	168	196	Wyoming	6	4
Mississippi	19	34	Canada	18	38
Missouri	204	267	United States' Possessions	37	42
Montana	25	24	Foreign	11	13
Nebraska	20	28			
Nevada	2	2	Total	6,551	7,853

The Public Health Nurse*

It is not easy to write a good radio speech. We think Dr. Dowling has been successful and we are printing his remarks with the idea that his approach and method may be helpful to others—particularly to those who may be planning to enter the radio contest described on page 438.

SOON it will be 1934. Nearly twenty years have passed since those grim days of 1914, when a world responded to the call to arms. A third of a lifetime, a fifth of the most remarkable century in history, separate us from the fast receding life of those war years. Since that almost ancient day radio and automobile and airplane are but three of the thousands of similar influences which have come upon and transformed the American scene. Though the stress and struggle, the heartaches and clamor of those years seem far away and long ago, in many ways our life of today is in the throes of a similar marshalling of effort in the face of a great enemy; not war this time, but pestilence and famine.

Of the figures before the public mind of the war years, none loomed larger and brighter than that of the Red Cross nurse. Today there is an equal, if not a greater, need for nurses on the battlefield on which is being fought a more or less desperate struggle for economic existence. Organized nursing is playing no less important a part in the war of 1933-34 than in that of 1914-18. Today the public health nurse is playing the same role that she played twenty years ago, though her name be different and the details of her task somewhat changed.

Let me tell you something of the story of community nursing as it has been enacted right here in America during the past twenty years. The public health nurse needs someone to tell her story, for in spite of the large dividends she has returned to her community in the saving of human lives and the prevention of suffering, there are many people who do not comprehend her place in modern life, nor do they understand what her objectives and functions really are, nor have they heard of her remarkable achievements. Dealing with such "intangibles" as birth, death, health, sickness, pain—the average person is prone to overlook her problems, her triumphs and achievements in favor of those of people who build with wood and stone and steel.

Just who are public health nurses, and what are the general objectives of their profession? They are graduate nurses, fully trained in modern hospitals and training schools, who, in addition to their basic nursing education, have had additional post-graduate instruction and training in the principles of their specialty, public health. They are nurses employed full time, by organizations supported from community funds, derived either from taxation or voluntary subscription.

"Public health nursing is an organized community service, rendered by graduate nurses to the individual, family and community." Its basic fundamental mission is the education of individuals and families in the protection of their own health. The nurse is the great health educator: carrying into the individual home, of whatever economic and social level it may be, the message of modern preventive medicine. And surely it is a vital message, sorely needed. Consider, on the one hand, the 125 million dollars spent annually by the American people on medical cults and fakes, and the 360 million dollars spent for "patent medicines",

*A radio talk by Dr. J. D. Dowling, Health Officer, Jefferson County Board of Health, Birmingham, Alabama. Station WAPI, May 11th, 1933.

for the most part worthless; and on the other hand, consider tuberculosis, the preventable disease, third leading cause of death! Consider also the enormous toll exacted, even in this enlightened day, by diphtheria, smallpox, typhoid fever, malaria, hookworm—all completely preventable. Surely there is a vital need for health education and for the public health nurse, with her primary responsibility for interpreting health to the individual family.

In carrying out this purpose, she has many specific tasks. Bedside care of the sick, of course, is the basis of all nursing. The public health nurse must be prepared to give such care to those in desperate need. But since she is called upon to serve, in the average American city, four, eight, ten thousand or more people, the time she may devote to the individual must necessarily be limited. For this reason, her duty lies in the instruction of others in the art of giving this bedside care. Careful instruction of some member of the family—the mother, usually—may mean the difference between life and death; between a long illness and a rapid convalescence; between life-long after-effects and complete recovery.

The public health nurse must make frequent visits to the homes of those ill with acute communicable disease, for such patients present special problems to the individual, the home, the state. There is, of course, first of all, the danger to the family. Tuberculosis, for example, is largely a family disease, transmitted from the affected to the well within the family circle. Smallpox, typhoid fever, and all the diseases of childhood, such as measles, scarlet fever and diphtheria, which are the diseases of contact, present dangers to those members of the family which must be guarded against. Then there are the dangers to other families; to the community at large. Most of the communicable diseases have a tendency to travel in epidemic waves and may only be subdued by hygienic care of the sick. By giving instruction in such matters as disinfection, isolation, individual immunization, screening and general sanitary care of those ill with communicable diseases, the public health nurse has played no small part in the reduction of epidemic diseases and has made it possible for men to live in spite of the crowded contacts of today.

Her great task lies in the field of maternal and infant care. By assistance to physicians at prenatal clinics, and by instruction of prospective mothers in the hygiene of maternity, both in classes and in the individual home, she carries on toward the day when humanity shall have conquered the most tragic of all death rates. In America 16,000 mothers die annually in childbirth. It has been proved time and again by actual concrete demonstration that three-fourths of these deaths are preventable. In a certain American city last year a total of 5,100 children were born. For every thousand of these children eleven mothers died. During the same year among the mothers attending the prenatal clinic operated by the nursing staff of the Department of Health of that city, only five mothers per thousand, less than half as many as in the city as a whole, died in childbirth, notwithstanding the fact that mothers attending the clinic were very largely from the lower economic and social level, in which the highest maternal mortality might reasonably be expected.

After the child is born, the public health nurse brings to the mother, harassed with the countless problems of infancy and the preschool years, the knowledge and aid which the modern profession of nursing has devised. Through individual home visits, through health centers, through mothers' classes, through correspondence, and through every channel that is open for communication, she carries the knowledge and actual physical skills for the prevention of childhood diseases and the promotion of child health. Truly the wealth of a nation lies in the health of its children.

The influence of public health nursing does not end when the child has entered school. A healthful school environment—health training and instruc-

tion—health supervision—these are very weighty terms covering such things as the correction of physical defects, provision of adequate lunches, the checking of growth and physical development, and many others, in all of which the school health nurse has no small part. Through her services the schools of today are educating a generation equipped for healthful living as no previous one has ever been.

The story of the public health nurse would not be complete without mention of her part in the control of the great plague, tuberculosis. Tuberculosis is a preventable disease; a disease which slowly but surely is being conquered. In spite of this fact, tuberculosis is still third leading cause of death in the United States, and the leading cause of death in the late teens, the twenties and the thirties. Through her assistance to physicians at tuberculosis clinics, through visiting in their homes cases of tuberculosis, arrested cases, and those who have been in contact with tuberculosis, by bringing suspected cases and contacts to clinics, and by general instruction of patients and their families, she is bringing nearer the day when tuberculosis will be a medical rarity.

There is scarcely a disease, scarcely a maladjustment in the life of the individual in which the public health nurse cannot aid with her training. Within the limits of time, much that she does must remain untold. The control of venereal disease; the dissemination of knowledge regarding vaccine and serum therapy; the control of specific diseases like diphtheria, smallpox, typhoid fever—all are her field.

Almost a century ago Disraeli, England's far-seeing Prime Minister, said: "Public health is the foundation stone upon which rests the strength of a nation and the happiness of a people: the public health should be the first consideration of a statesman."

The protection of the public health is the most vital charge on government. In this activity the public health nurse has an exceedingly important part. Especially in this time of economic stress her services are a grave necessity. Sickness is always an extravagance which the individual and the community can ill afford. Today it is an intolerable drain on human resources. Sickness is largely preventable. Said Dr. Hermann Biggs: "Public health is purchasable. Within natural limits, any community can determine its own death rate." One important way in which a community may purchase health for its citizens is with the skill and knowledge and ability of modern community nursing. Such an expenditure is an investment which returns dividends in health and life itself.

SOME ARTICLES OF SPECIAL INTEREST IN THE AMERICAN JOURNAL OF NURSING FOR AUGUST

A Community Serves Research

By EMMA RAE McLEOD, R.N.
and
MARGARET B. WRIGHT

IN the summer of 1930, the Biological Laboratories of E. R. Squibb & Sons, New Brunswick, N. J., were engaged in a study of a principle found in the urine of pregnant women. As a consequence an ample supply of such urine was needed and in the furtherance of this work a representative from the Squibb Laboratories consulted with the Director of the Visiting Nurse Association of New Brunswick as to ways and means by which such urine might be obtained. He explained the difficulty of securing urine satisfactory in all particulars and thought that such might be obtained through the coöperation and facilities of the Visiting Nurse Association. The Director made out a list of expectant mothers, who might be glad to earn some money in this way, and after consultation with the staff, six prenatal patients were selected and a routine arranged with the Squibb Laboratories for a trial period.

At the end of three months, the Laboratories were convinced that their product would prove a valuable aid in the treatment of certain conditions.* At this time they asked for an increased supply of the urine of pregnancy, collected between the third and eighth months. Again the Director and the staff consulted and more patients were put on the Squibb list. At first the mothers were paid by volume, but this method proved unsatisfactory, because of the temptation to falsify the quantity, and a flat rate of pay was therefore agreed upon. It was understood that three one-gallon jugs of urine, containing the total output of each patient, be turned in to the Visiting Nurse Association office each week to be collected by Squibb. During the first year there was distributed to the women a total sum of $1000.00. In the two and one-half years, during which time this plan has been in operation, a total of $8000.00 has been distributed to 199 expectant mothers.

Considerable time was given by the Visiting Nurse Association in supervising this service and in consulting with the Squibb Laboratories. The sanction of the Medical Advisory Committee of the Visiting Nurse Association was secured at the initiation of the plan and the Committee was consulted again later in the experiment. Each nurse selected prenatal cases in her district, explained

*The product must be used under the direction of a physician. It is described as a preparation which is "a standardized extract of pregnant urine containing the anterior pituitary sex hormones according to Zondek and Aschheim. We have found it possible to make active extracts which contain the follicular stimulating and luteinizing hormones and also the ovulating hormone. These are non-toxic and have a wide application in the following conditions:

1. Infantilism—Where the girl passes the age of puberty with practically no development of the secondary sex characteristics and who has rudimentary or infantile genital tract.
2. Primary Amenorrheas—Where girls have passed the age of puberty but have not yet menstruated although anatomically they appear practically normal.
3. Secondary Amenorrheas—Those cases in which menstruation has been established but after some time has become scanty, irregular, and has ceased altogether. This is sometimes also associated with what is called the pituitary headache or Migraine, and with the development of obesity, particularly the girdle type.
4. Primary Menopause—When the symptoms of the menopause appear several years before they are reasonably due, frequently it is assumed that the anterior pituitary gland is involved and this should therefore be of value in such cases.
5. Sterility—On account of the presence of the ovulating factor and based upon animal experimentation we anticipate that it may be of value in the treatment of human sterility provided, of course, that there are no pathological or anatomical reasons for the sterility."

the purpose of the plan to the patient, taught the patient the collection routine and checked up on any failures. The office staff supervised the exchange of bottles at the office and took care of the cash payments received from E. R. Squibb & Sons.

There were definite advantages growing out of this plan, which will be considered here under the topic headings—

Educational advantages to staff and patient
Social service relationships
Medical contacts

EDUCATIONAL ADVANTAGES

The selection of a patient called for considerable constructive thought. The nurse had to obtain a thorough knowledge of the affairs of the family and to use her ability in teaching each patient her responsibility in carrying out the details of the plan. The first consideration was the financial need of the family. This information was secured through consultation with the community social agencies. The nurse then considered the information she secured concerning the family, its income and condition, and made a plan with the patient, the physician, and the relief agencies for the use of the money earned. In order to make a project of this sort valuable to a community, the nurse had to be sure that the money was spent wisely. The patient had to be given an opportunity to increase her knowledge of budgeting and planning. She had to be taught not to spend her money as soon as received, or all at once on some unsuitable or extravagant item, but to save it for her hospital fee, her doctor's bills, her nursing service or for the needs of her expected baby.

Therefore, each nurse worked out a plan by which the mothers deposited in a mothers' fund, with the Visiting Nurse Association, some part of their weekly receipts. Squibb gladly coöperated in this scheme, and sent the cash payments to the office and these were paid to the mothers in divided amounts according to the plan.

Each nurse had also to teach her expectant mothers how to collect the urine. If for any reason, pathological or chemical, the urine failed to measure up to acceptable standards, the Squibb Laboratory notified the Visiting Nurses' office and the nurse in turn reported this to the private doctor, the hospital clinic and the patient. It was the duty of the nurse to explain to the patient the abnormality or unfavorable findings, so that she would understand and could rectify the condition. The fact that payment would have to cease if the urine showed continued abnormalities, influenced each patient in her desire to follow accurately the nurse's instructions.

One of the very interesting indirect developments of this plan grew out of the Squibb Laboratory report on the absence of certain chemical constituents in several urine specimens, apparently due to faulty diet. Since there was no nutrition worker on the staff of the Visiting Nurse Association, the problems were referred to the Home Economics Department of New Jersey College for Women in New Brunswick, and the nutrition specialist, the students in the department and the staff nurses of the Visiting Nurse Association worked together on the dietetic problems—an educational experience in itself for staff, students and patients.

SOCIAL SERVICE RELATIONSHIPS

Quite naturally, the mothers who were deemed eligible for the Squibb payment plan were frequently members of families on the relief rolls of the city, or receiving aid from some other source. The following questions arose: Should not the money received by the mother be considered a source of income and be deducted from the weekly relief allotment? Should a mother receiving this sum be given free hospital care in a city bed? Should she not be expected to pay a doctor if she was delivered at home? Private doctors, the city physician, the hospital, the Emergency Relief Administration, the charity organization and the Overseer of the Poor were all called in to discuss these questions. The result was that each agency acquired a much clearer understanding of the work of every other agency.

MEDICAL CONTACTS

Probably the most productive result of this unique plan has been the unanticipated strengthening of relationships with the medical profession. At the start of the plan the Medical Advisory Committee of the Visiting Nurse Association gave its approval. (It should be said at this point that the Research and Biological Laboratories of E. R. Squibb & Sons are under the direction of a licensed physician.) As each patient was placed on the Squibb list, her physician was notified, and the visiting nurse reported regularly to the physician on his patient's condition.

Shortly after the plan was under way, the assurance of freedom from venereal disease became important and Squibb requested the Medical Advisory Committee to consider how patients supplying urine could be tested for syphilis and gonorrhea and offered the facilities of the Squibb Laboratories for these tests. The Nursing Committee of the Visiting Nurse Association then met with the Doctors' Advisory Committee of the local medical society to discuss a plan for securing this information. It was decided to write to the physicians in the city, who were caring for maternity patients, explaining the plan. The letters were sent over the signature of the Director of the Visiting Nurse Association and stated the decision of the Doctors' Advisory Committee to be:

"To accept the Squibb plan, whereby each prenatal patient will consent to have a smear and Wassermann taken by the Squibb Laboratory—a confidential report of the findings to be sent to each prenatal patient's physician."

"To send a copy of this letter to each patient's physician explaining the plan and to ask his coöperation."

A space for the physician's signature was left at the bottom of the letter. All physicians receiving this letter were heard from and all consented to the plan as presented by the Visiting Nurse Association.

All in all, this unusual plan has been of great service to the patients, the research laboratory, the social agencies, the private doctors, the hospitals and to the community in general.

THE 1933 CONTEST

We remind our readers of the annual contest conducted by this magazine, which will be this year for the best radio sketch presenting the whole subject of public health nursing or any phase of it. The sketch may be in the form of a dialogue, a dramatic sketch, a playlet, a story, or a recitation of any kind; it may concern one patient or many, the preventive or curative side of the work, the state, county, or local program—*but it must tell something of importance about public health nursing in a way that will make people listen* and be appropriate for the radio. It must not consume more than 12 minutes to present and therefore should not be longer than 1,500 words, shorter if possible. The contest is open to any one. Individuals may send in as many entries as they wish. The three judges will represent the public health nursing field, the non-professional radio audience, and the radio broadcasting experts.

The contest closes midnight, October 15, 1933, and the winning sketch will be published in our December number. It is hoped that it will also be possible to arrange for broadcasting the winning sketch—either locally or nationally as seems appropriate.

PRIZES:

1st Prize—$20.00 2nd Prize—$10.00 3d Prize—$5.00

Manuscripts signed by a pen name should be sent to Contest Editor, PUBLIC HEALTH NURSING, 450 Seventh Avenue, New York City. They should be accompanied by a sealed envelope containing pen name and real name and address of the author.

Informing the Public and Money Raising

A Résumé of Recent Methods in Sixty-five Public Health Nursing Associations

By ALMA C. HAUPT
Associate Director, National Organization for Public Health Nursing

THE present economic dilemma makes the importance of informing the public about public health nursing more evident than ever. There are two special reasons for this: because more families are in need now of part time nursing service, being unable to afford private nursing care, and because agencies are facing a loss in income and an increasing free case load.

Our goals should be that every one who needs part time nursing service at home should know where to turn for it, and that every one able to share in the support of such health service be asked to do so.

Does the public know in the midst of all the swiftly changing currents of thought and practice what nursing service it may get through its health department, what is offered through the schools and industry, and what is available through the private public health nursing associations? Has that part of the health program which must be supported and continued through private gifts been brought to public attention? Educational publicity on this last point was never more needed than now.

In June, 1933, 65 urban public health nursing agencies answered a questionnaire sent out by the National Organization for Public Health Nursing regarding publicity and money raising. It is from the experiences of these cities that the following suggestions are offered to supplement the detailed material on publicity published every month in this magazine from September, 1932, through May, 1933.*

PUBLICITY

The Work Itself: Good service stands first as the best form of publicity. One agency aims to render "a service without complaint from the people to whom it is rendered." Nurses in crisp, professional uniforms carrying well-kept bags, are constant public reminders of the service. Agency-owned cars in a good state of upkeep also serve to draw attention to the organization.

The Written Word: A card or a small folder, giving the address, telephone number of the agency, cost and types of service, should always be available, widely used, and left in every home visited. The nurses may suggest keeping it in a conspicuous place near the telephone, in the bedroom mirror, beside the kitchen clock, sometimes in the family Bible. In one community, mimeographed, illustrated announcements of clinics for colored people are passed out to the congregation at colored churches.

The accompanying illustration shows a cardboard disc to use on the telephone, giving information about the service and space for other commonly used telephone numbers.

The newspapers are the chief medium used by the agencies reporting. One ingenious group gets committees of lay people to study the services of the agency and to send reports to the newspapers.

One agency mentions preparing a special column on "Your Baby's Health"

*Publicity Study Program—single copies free to N.O.P.H.N. members—to others, seventy-five cents for the series.

run in a local paper for three months during the summer. Another wrote a series of ten articles entitled "Solving the Nursing Problem." In one city, a "Baby Edition" of the Sunday paper gave a splendid résumé of all the local facilities for care of the child to which commercial firms responded by pointing up their advertising to the subject. In another city, one whole rotogravure section was devoted to public health nursing. One agency reported the placing of paid advertisements of its service in the local papers.*

—*Courtesy of the Instructive Visiting Nurse Association, Richmond, Va.*

For the Telephone

Public health nursing is bursting into print in magazines, as well as in the daily papers. Local house organs, medical journals, other professional magazines are listed as carrying material for local public health nursing agencies.

Annual reports have been depended upon as a strategic medium of reaching the public. With recent budget limitations these reports have been considerably condensed. A few agencies omitted their publication this year. Most of them, however, got out reports which, through their very brevity, may have additional merit.**

For broad distribution to potential users of the service as well as to potential givers to it, several agencies use fliers which can be tucked in monthly bills from commercial firms. An adaptation particularly pertinent to the nursing situation is the inclusion of such fliers with all prescriptions sent out from drug stores.

One agency mentions the distribution of blotters, advertising the nursing service, to all children and teachers in the public schools. Another is justly proud of a combination blotter, bookmark and six-inch ruler given out through public and circulating libraries.

On the Air: Increasingly local public health nursing agencies are broadcasting their services over the radio. A three-minute program given three times a week has proved to be a successful plan in one city. (See also page 443 in this magazine.) In another place, a "Mighty Oracle" obligingly answers questions for the public and includes questions about the Visiting Nurse Association.†

Exhibits, Posters, Pictures: Several phases of public health nursing lend themselves to such public displays as exhibits.

In one city, the conspicuous front yard of the Visiting Nurse Association has a large bill board placed strategically near the street in full view of pedestrians, and passengers in street cars and automobiles. A series of 9 large posters suitably framed are used on this bill board. Each poster has a series of captions. These captions and the posters are frequently changed to catch the public's interest in various phases of the service. Some of the spicy captions used with these may be suggestive to other groups:

"When leaving the hospital you may need me."

"A nurse for every purse. The Community Fund pays for those with an empty purse."

"There is no substitute for good nursing."

"In one hour, we make your sickest friend

*See also PUBLIC HEALTH NURSING, November, December, 1932.

**See also PUBLIC HEALTH NURSING, April, 1933.

†See also PUBLIC HEALTH NURSING, February, 1933.

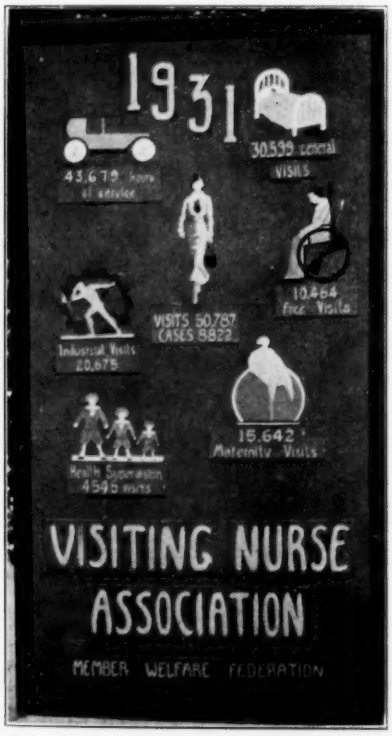
feel better. Call a visiting nurse. Get the best."

"We repeat our service. Why? Because we give good service."

"A sick man can't hold a job. We help you to health."

"Invest in health—a safe investment. The visiting nurse will be your broker. Call Pros. 3910."*

The accompanying illustration from the Visiting Nurse Association of the Oranges (N. J.) shows a clever and effective use of cut-out silhouettes and figures in poster form.



This poster was made of light weight beaver board, painted orange. The figures were made of bristol board, drawn, colored, cut out and pasted on the beaver board.

Home Visiting: There is no better way to appreciate the full meaning of the service than to see the nurse actually at work in the homes. Due to the intimate nature of her task, the nurse finds it difficult to take even the most sympathetic observer with her on her calls. However, where the nurse has the *consent of her families* and where other circumstances permit, the director may invite certain carefully selected individuals to visit with the nurse. One agency shared this experience with the wife of the city manager, another with a newspaper reporter, a third with a writer of note. Several executive directors feel that this is the best opportunity for helping board members to understand local problems. The increased use of volunteers has also been a means of broadening community appreciation of the nursing work.

PUBLICITY IN RELATION TO COMMUNITY CHESTS

In community chest cities, the publicity programs of the public health nursing agencies are often worked out with the help of the publicity worker employed by the chest. Even though agencies cannot employ full- or even part-time special publicity workers, they may carry the work through a publicity committee of the board, with the help of the nurse director and the staff. Every large community has writers, artists and advertising experts who make helpful members of this committee.

The blending of chest and individual agency publicity is of course essential. One chest accomplishes this through sending its publicity director to visit each agency every month during the year and to make contacts with members of the agency's publicity committee, making special effort to be present at the agency's meeting at which year-round plans are made. In another situation, house to house canvassers are sent out by the chest to explain the functions of the agencies. One visiting nurse association obtains from the chest a selected list of contributors to whom it sends its annual report immediately before the chest campaign.

*See also PUBLIC HEALTH NURSING, March, 1933.

MONEY RAISING

Methods of Presenting Budgets to Community Chests: It is generally felt that the allocation of community chest funds is dependent not alone on the amount of funds available, but very decidedly on the knowledge and understanding of the chest group. Written reports and personal contacts with the chest budget committee are both emphasized by the questionnaire replies. Monthly financial figures are generally sent to the chests on forms provided for the purpose. Annual reports of the agency are submitted.

The budget itself usually is accompanied by a carefully prepared letter of explanation. Some of the items mentioned as included in such a letter are: reasons for increase or decrease in service and in budget; the relation of changes in services to changes in local need; statistics regarding the number of visits, number of individuals reached; and the number of conferences held and groups reached.

One agency prepares charts showing health conditions, demands for service, the trend of support from chest and other sources. The letter of another agency emphasizes adjustments due to the present economic situation and includes studies made of the income of families reached by the service and the nutritional status of the children. Still another organization includes in its budget presentation an exhibit of the benefits obtained through corporate membership in the N.O.P.H.N.

In one instance, salary schedules were substantiated by the actual personal budgets of the nurses showing their professional financial obligations as well as their living expenses.

Agency representation at the budget hearing is variously reported as follows: president, vice-president and treasurer; president, treasurer and nurse director; president, secretary, treasurer and nurse director; president, chairman of finance committee, health officer and nurse director. In one city the whole board attends the chest hearing in preparation for which it conducts a rehearsal. Another plan is to have one member of the agency's finance committee contact one member of the chest budget committee in advance of the hearing. Some agencies discuss the budget in detail with the chest executive before presentation. It is imperative that each representative of the nursing agency who goes before the chest budget committee understand in complete detail the budget the agency is submitting.

Reversing the picture, we find many chests definitely seeking contact with their member agencies. One chest sends a member of its finance committee to visit the nursing service two or three times a year. Sometimes a board member of some other chest agency is asked to study the budget of the nursing association. Frequently chest officers attend the annual meeting of the public health nursing service.

Other Means of Raising Money in Chest Cities: A few public health nursing associations have been permitted by the chests to raise contributions by special effort (in addition to the chest campaign) in cities where the chest funds have been drastically cut. It is made clear to contributors that this is an emergency measure.

The chief methods used are the solicitation of contributions in kind, benefits, endowment funds and memberships. Agencies reported receiving such gifts as free office space, transportation, medical supplies and layettes. One agency asked lay organizations making surgical supplies to donate the materials used.

Memberships in the association, usually of from one to five dollars, form an important source of revenue. One interesting adaptation of the membership plan is described as follows: Instead of asking membership dues the finance committee decided to offer tickets for nursing service, transferable when endorsed by purchaser. The price is $1 per ticket or six tickets for $5, each ticket entitling the holder to one nursing visit.

Methods of Money Raising by Agencies not in Community Chests: Of the sixty-five agencies answering the questionnaire, only three had the entire re-

sponsibility for raising their own funds. These were all in large eastern cities. The board of directors takes an active part in the planning and carrying out of solicitation.

Intensive campaigns in which lay friends are organized into teams with captains were used. One agency felt it unwise this year to have a large public "drive" but succeeded in getting its budget quietly.

One successful plan has been to have appeal letters sent out by well-known authors. Ernest Poole and Fannie Hurst have lent their names to the cause. Prominent local citizens, some with national reputations have done likewise. Perhaps in your own community there is an outstanding leader who would be glad to give your work endorsement through the use of his or her name.

The belief of one agency is worth noting—that the success of mail appeals for funds rests with a "year-round press and speaking publicity program."*

In conclusion may we remind our readers that publicity loan folders, recently revised, containing many of the devices mentioned above are available through the N.O.P.H.N. on the following subjects:

Annual Reports
County Fairs and Window Exhibits
General Publicity Information
Movies
Plays and Pageants
Posters
Publicity Novelties
Radio

*See also PUBLIC HEALTH NURSING, September, October, 1932.

Radio Publicity

The Visiting Nurse Association of Minneapolis, Minnesota, has been trying out a new form of publicity for its hourly appointment service:

During the day in pauses in the local broadcasting programs—between programs—the radio "Time Signal" announcer, without preliminary explanation, broadcasts a very brief statement about the convenience of the hourly service, finishing off with the V.N.A. telephone number. None of these statements is more than a hundred words—many are shorter. The plan was worked out by the publicity committee of the Visiting Nurse Association board and the publicity director of the Council of Social Agencies. A few samples of the kind of message sent over the air follow:

Have you a case of illness in your house? And are you at a loss to know what to do to make your patient comfortable? Why not get a Visiting Nurse at Main 5275, to carry out your doctor's orders? She is a graduate nurse who knows more about your problems than you do, and is the most modern type of help you can get. Pay as you go—$1.00 for the first hour, and 25 cents for every succeeding half hour—"Cash and Carry" is the idea—Remember, 'There's a Visiting Nurse for every Purse.' Call Main 5275.

Has your physician ordered special treatment for a member of your household? That means a graduate nurse, and you can find just such a well trained person through the Visiting Nurse Association. Maybe you didn't realize that in addition to free care given the needy, the Visiting Nurses maintain a pay service designed to meet just such an emergency. The charge is $1.00 for the first hour, and 25 cents for any part of an additional half hour. You have only to call Main 5275.

We used to consider a trained nurse at the bedside a luxury beyond our purses. But things have changed—through the pay service of the Visiting Nurse you can have a well trained person to carry out the doctor's orders in your home at a very moderate cost. In addition to the free care given the needy, the Visiting Nurses are prepared to meet the requirements of those able to pay a modest fee. The charge is $1.00 for the first hour, and 25 cents for any part of the additional half hour. Call Main 5275.

The "T. E. R. A. Nurses" in Syracuse, N. Y.

By CATHLENA A. COOPER
Director, Visiting Nurse Association, Syracuse, N. Y.

As we promised, we have secured accounts of how three public health nursing agencies are administering the work of the "T.E.R.A. nurses" (relief nurses) provided by the New York State Department of Health under the Wicks bill, as described in Miss Sheahan's article last month.

THE Wicks act of 1931, establishing the Temporary Relief Administration in New York State, specified medical care, as well as food, shelter and clothing, as a necessity of life, to be furnished to recipients of home relief during this emergency period. Good medical care always includes nursing care and as surveys* showed the need of more nurses for the acutely ill in the home, unable to pay for such service, Syracuse was allotted fourteen graduate nurses, and Onondaga County four. Although these nurses are paid through the State Department of Health and are not attached to the regular staff of the Visiting Nurse Association, they are directly under the supervision of the District Health Officer. They have an eight hour working day, and a five day working week.

HELP WITH THE CASE LOAD

During the month of March these fourteen nurses made 1,276 visits to 377 patients. Many of the patients were seriously ill with pneumonia, too ill to be moved to a hospital and it is due to excellent nursing care that no deaths occurred. Care was so arranged that "group nursing" was made possible, each nurse caring for from two to three patients each day. Special duty, both day and night was allowed when the patient was critically ill, or when the mother was the patient and alone in the home with very young children.

During March the case load of the Visiting Nurse Association was almost too heavy for the depleted regular staff. Due to cutting the budget, the number of nurses reverted to that of 1925, yet March showed a peak in case load greater than in any month of March for the past three years.

April found the case load of the acutely ill patients decreasing, so that one relief nurse was transferred to the Bureau of Nursing, Department of Health, two nurses to the staff of the Syracuse Free Dispensary and one added to the group of four nurses working in Onondaga County. April also found the State allotment for this nursing service cut from thirteen to eight nurses. The nurses reached an agreement among themselves that they would rather share the work among the entire group by working half time than reduce their number to eight nurses. From April to the present, each of the 13 nurses is working three days a week, an eight hour day and earning $10.50 per week. Naturally the three-day-a-week plan is staggered throughout the week so that an even balance of nurse-power is kept.

The undergraduate student group affiliating with the Visiting Nurse Association changed April 1st, and to the class of incoming students was added the ten T.E.R.A. nurses who had been working on the agency staff. These nurses were fully aware of the value of the student introduction and attended many of the conferences and demonstrations in their own time.

EQUIPMENT

The question of the cost of equip-

*See New York's "Experiment in Double Relief" by Marion W. Sheahan, PUBLIC HEALTH NURSING, July, 1933.

ment for the nursing bag proved to be a problem to both the T.E.R.A. nurses and the agency. The nurses could not be expected to meet the full cost of an equipped nursing bag nor could the agency be expected to invest such a sum for equipped bags which might be used for an emergency period only. Again a compromise was reached: The nurses bought an inexpensive bag which they later could use in private duty and added to it the equipment they already owned as private duty nurses which luckily was the most expensive part of the bag equipment (instruments, hypodermic and enema tubes). The agency supplied the linen, green soap, hypodermic needles, Stewart's Solution, etc. In conferences with the T.E.R.A. nurses it was discovered that they felt it might be well worth while for every private duty nurse to carry a bag equipped for practically any treatment such as a visiting nurse's bag. Bag technique has held particular interest for the relief nurses because the bag is self- rather than agency-owned. The bag with its zipper top is lined with a pre-shrunk lightweight canvas lining, with pockets and straps to hold the bottles and record materials, snaps holding the lining to the bag. Each nurse made her own lining, the entire cost of bag and necessary new equipment averaged $4.75. Additional office equipment was necessary and was loaned by the Department of Health and the Y.M.C.A.

The nurses' uniforms are a plain blue with white collar and cuffs, purchased by the nurse and, usually, made by her. A plain black felt or straw hat with a plain dark coat furnished by the nurse complete the outdoor uniform. In a few instances the agency has been able to lend one of its extra staff coats, and when this has been possible the ensignia on the sleeve has been removed.

Carfare has been kept at a minimum, the cases being grouped either near the office or the nurse's home. The carfare per nurse per month (three days a week) is at present averaging $1.25 per nurse and is paid by the nurse.

INTRODUCTIONS AND SUPERVISION

The introduction to the field was exactly as the student introduction with the exception that the T.E.R.A. nurses carried only those patients active in the file of the Department of Public Welfare. With very few exceptions this policy was strictly adhered to, as it was the original intention of the Wicks Bill that this particular nursing service be given to the indigent sick only.

Supervision has been given as it is given to student and staff. It is through field supervision and the conference which follows that the private duty aspect of nursing is changed from its focus on the patient alone to the patient in the family group. The health of the entire family is shown to be quite as important as that of the individual patient. By enlarging the nurse's perspective and her viewpoint, together with showing her the opportunity of teaching health habits to all age groups rather than giving only the remedial care to the patient, we believe we are offering something of value to this group which they will take back to private duty. Supervision of actual nursing technique, together with supervisory guidance in the social problems of the families carried, will also, we hope, create a desire to develop guidance through supervision in the field of private duty nursing.

REGISTRY CO-OPERATION

A helpful plan for these nurses has been worked out with the Official Registry of District No. 4. The Registrar is given a list of the nurses' free days during the week and if possible (and always when asked for by physician, hospital or family) calls the nurse for private work. The Visiting Nurse Association readjusts the working days so that if the nurse is called, she may earn from special duty service and at the same time give three days to the agency as a T.E.R.A. nurse. In this way several of the nurses have added to their small income of $10.50 per week.

Rochester's Experience

By CORA WARRANT
Director, Public Health Nursing Association, Rochester, N. Y.

The problem of supervising twelve work relief nurses is one which the Rochester (N. Y.) Public Health Nursing Association faced on February 15 of this year just a few hours before their arrival. It may interest other agencies to learn of our experience in order that they may avoid our mistakes if a similar problem should be presented to them.

The writer is assuming that readers have read about the general plan of assigning Temporary Emergency Relief Administration funds to the New York State Department of Health for the double purpose of providing skilled nursing service to dependent families and of providing employment for needy nurses. The decision as to where these relief nurses for Rochester should be placed was made by the District State Health Officer in conference with our local Health Officer. The only funds which were available for this nursing service from the State Department of Health were the nurses' salaries. No provision was made for nursing bags, supplies or transportation.

A brief manual of instruction from the State Department of Health outlined a standard bag technique, instructions regarding professional appearance and equipment as well as detailed instruction regarding nursing care in the various services. The manual was used as a basis of instruction, being almost identical with our own nursing technique.

The nurses presented themselves in a variety of garments, including fur coats. Several wore white uniforms, others colored undergraduate uniforms, while a few wore silk or woolen garments. Shoes were mostly of the spiked heel variety. The nurses appeared discouraged and worried.

ADMINISTRATION

Plans for supervision of the work were hastily made. Our staff educational director was made responsible for the introduction of the nurses to the field, which because of the uncertainty of their length of service, was not planned as intensively as for our new staff nurses. This proved to be our first error, since, we later found it necessary to give them as much instruction as the others, if not more.

One of our general supervisors was assigned to the relief nurses for office supervision, and one of the consultants was assigned to assist her, especially in the matter of supervision in the field. The nurses were provided with our standard bag equipment including the apron. Heavy cuts in the organization's income made it impossible to assume the expense of their laundry.

INTRODUCTION TO THE FIELD

The standard bag technique was demonstrated to the group by the educational director. The nurses were then sent into the field to observe general and surgical care with our staff for the remainder of the day. A demonstration of general care was then given and several cases of general care were assigned. Surgical care was next presented in the same manner. In a few days it became necessary to demonstrate the technique used in communicable disease since there were many patients needing this care. The nurses have coöperated in a city-wide immunization program.

A conference on social agencies and community resources was given early in their experience since the nurses were limited to service in the homes of families who received either home or work relief. They were also instructed in the use of our Supply and Lending Bureau, especially as it relates to city or county orders for dressings, for which the organization receives payment as ordered by medical agencies.

The nutrition worker has given nurses conferences from time to time on budgets and diets for families on minimum food allowances. Instructions have been given regarding pamphlets which are issued bi-weekly by the Nutrition Consultant of the Department of Public Welfare as a guide for meal-planning and buying. These pamphlets are distributed with grocery orders to all dependent families. The nurses are in a key position to give nutrition guidance since they enter homes receiving relief.

Postpartum and newborn care was demonstrated next. The nutrition worker then demonstrated the preparation of a formula in the home. Prenatal care, including blood pressure and urinalysis was shown after the nurses had worked with us for about a month. Instruction in infant and preschool health supervision was given first to those best prepared to do educational work. The nurses joined the usual classes for student nurses in the introduction to the field whenever it could be arranged.

Our tuberculosis consultant had a conference with the group and explained our technique and methods of supervision in families presenting tuberculosis problems. The nurses are responsible for contacts under supervision in families in which they are giving nursing care. Staff nurses have retained those families which are most difficult and those in which only long time supervision is needed.

SERVICES RENDERED

One service which the T.E.R.A. nurses may render, but which has been little used in Rochester, is that of special duty for acutely ill patients. The nurses have given this type of care where it seemed necessary in acute cases only. It would, however, be very expensive if continued for any length of time. It reduces the number of persons served, especially if three eight hour shifts are required. Such patients might be more economically cared for in a hospital. The service has proved of most value when the nurse has assisted in the home for four or eight hour periods. One danger is that nurses may be imposed on by patients who are not acutely ill. It has been difficult to determine eligibility for the service. The problem of providing nursing care at night without advance warning is a very real one for the director. Nurses who report for day duty cannot lightly be asked to work another eight hours at the end of their day.

The work assigned to the T.E.R.A. nurses was carefully selected by their supervisor from the beginning. The financial standing of the patients had to be determined to be sure of their eligibility for care. The background of the nurse had also to be considered since some had been out of training twenty years. Others were recent graduates. Several had limited experience, two nurses having had no maternity experience in training. Many of them had had only theoretical training in communicable disease technique. It seemed necessary to proceed slowly with these considerations in mind.

Experience has made the performance of the group more uniform. They now carry generalized duties in definite areas in the city. Conferences are held with the staff nurses working in the same area and with district supervisors.

Less supervision is now required in the office as the nurses have become familiar with our routine. Our record system is used by this group and a statement of their visits for the month, classified according to services, is sent to the District State Health Officer, to whom we are directly responsible. This report is, of course, kept separate from our own statistics.

GETTING ADJUSTED

At first there was a problem of filling in spare time before the nurses were prepared to carry all types of service, and before sufficient eligible cases had been selected. The nurses have employed this office time in making dressings and supplies for our Supply Bureau. This was only a temporary situation as letters describing the available service were sent to all relief agencies, dispensaries and other medical and so-

cial agencies who might have patients to refer.

Nurses rotate for duty in our classes for expectant mothers and preschool health conferences. They have attended group meetings and conferences when opportunity offers. A plan is now under way to send them to the conference on nutrition which is soon to be conducted by the State Department of Health in a neighboring county. Volunteers will make transportation possible under the leadership of our Nursing Committee.

Five of the original group of nurses have left and others had to be introduced to our service individually or with affiliated students when possible.

SOME PROBLEMS

Several other problems caused some difficulty and should be mentioned. Some weeks elapsed before the City Department of Public Welfare accepted the responsibility of paying car tokens for transportation. The greatest difficulty occurred when the nurses were withdrawn for a week because of a reorganization in the local relief set-up. This caused an enormous problem of adjustment of cases and reorganization of work when the nurses returned. Any turnover causes the supervising agency a difficult problem of administration. The more stable the service the better it will be for the patients, the nurses and the agency involved.

Many of the nurses have gained in health since coming to us. An effort is being made to have the group secure periodic health examinations and chest X-rays which are required of our regular staff. The County Medical Society has agreed to give the examinations for a small fee and the Superintendent of our local County Sanatorium has offered chest X-rays without charge. Several nurses have already taken advantage of these opportunities. The standard medical examination blank is being used as for the regular staff.

A committee, chosen by their group, has worked with the uniform committee of our Staff Council to solve their own particular uniform problems. A local firm has dyed their white uniforms for a nominal fee to a medium shade of blue, which differs slightly from that worn by our own staff. This made it possible to use uniforms already owned. There is evidence of pride in their professional appearance as a group.

RESULTS

The morale of the T.E.R.A. nurses deserves a real tribute. The nurses came to us a discouraged group. Regular work and income have brought to them renewed courage. They have shown a fine attitude toward their work, their patients and their supervisors. As time goes on we feel that they are developing a public health point of view.

The reaction of the group toward their introduction to the work has been very stimulating. It has been a source of satisfaction to hear the nurses express their appreciation of the effort made by the organization to give them a background for their service. Our library has been widely used by the nurses. In fact a surprising number of professional books have been circulated among them.

Our Nursing Association has also benefited greatly. The assistance of the T.E.R.A. nurses, especially in providing bedside care, has made it possible for our staff to carry more adequately its health supervision program. Days on duty are planned to include Saturdays and holidays as needed. This aid is invaluable during vacation periods when the regular nursing staff is depleted. A decreased income from Community Chest funds causing a reduction in nursing service has made this supplementary service unusually welcome.

The T.E.R.A. nursing service has been a boon to the nurses employed, to the supervising agency as described and to the community at large, since a reduction of private funds would have made it impossible for us to give adequate public health nursing care to many in need in our city.

How Yonkers Planned

By ALEXANDRA MATHESON
Director, Visiting Nursing Association, Yonkers, N. Y.

When the ten nurses under the New York State relief plan were assigned to Yonkers, the question of placing these nurses to the best advantage was our first problem. A conference was held with the Commissioner of Public Welfare, the Commissioner of Health, a representative of the State Department of Health and the Director of the Visiting Nursing Association, to consider a plan for using our nursing quota. The Visiting Nursing Association was assigned the direction of the work.

Because these nurses came on short notice, there was very little time to outline a plan of procedure. The one adopted as a beginning concentrated on the families of the unemployed. A health survey was made for the purpose of finding any instances of neglected illness or cases of malnutrition. It was planned that this survey would consider the unemployed family as a whole, with special emphasis on the "get-ready-for-school" child.

INTRODUCTION AND SUPERVISION

The nurses assigned for this work come with varying qualifications. The older nurses who have done nothing but private duty are assigned to stay with patients who need special nursing care, but are unable to pay for a private duty nurse. The nurses who have some background in public health and the younger graduates without experience are given the routine introduction to the field. (Only nurses who can meet required staff standards are employed.)

The bag technique is demonstrated with the improvised bag which is purchased by the nurse. The regulation bag is not required. The Visiting Nursing Association supplies all equipment for the bags.

The problem of laundry for so many nurses was one that the Visiting Nursing Association did not plan in its budget. This matter was discussed with the Commissioner of Public Welfare and arrangements were made to have this laundry done under a work relief plan.

The question of supervising these nurses was a problem. Again the budget had not been planned to provide an additional supervisor, so it was decided to use the staff nurses who are giving home supervision and assistance with the records. The staff nurses have shown interest and enthusiasm in this work.

The plan of health supervision and preschool work adopted in the beginning has been continued. Several instances of patients needing medical attention have been found. A good deal of attention is given to families who are living on a minimum budget. Many instances of malnourishment have been discovered, not so much from inadequate budget but from poor planning. A check has been made on families in which assistance has been given with budget-planning and it was found that the undernourished child showed a gain in weight with no addition to the budget.

An intensive campaign on the "get-ready-for-school" child is being conducted. This plan was worked out in coöperation with the principals of schools where nurses were assigned and the Director of preschool work of the Tuberculosis and Health Association. A preliminary analysis of this work shows a marked increase in the number of defects corrected.

NURSING CARE

Since the first of the year the demand for nursing service has increased at the rate of 1000 visits a month. This is due to a number of factors: A number of calls come from families who in good times were able to afford a private duty nurse; the workers in the Department of Public Welfare find many cases where a nurse is needed; special duty service still plays an important part—the families

where this service has been provided appreciating the help and relief from the responsibility of caring for these patients who would have had no care if this service had not been made available. Also, for the first time the Visiting Nursing Association here in Yonkers, has had the opportunity of using nurses of different nationalities—one, an Italian nurse, is doing an outstanding piece of health teaching in a most difficult Italian section; a colored nurse with an excellent public health and educational background is making a study of the health of the colored people.

IMPRESSIONS

Our first reaction to this plan was that there would be many difficulties in such a program. I can report with enthusiasm on its functioning. The spirit of the nurses employed has been good. They have adjusted remarkably well to all types of work. They have added inspiration to the whole work as well as filling our need for additional help. The Board of Directors and the community appreciated the need of an increased staff—in no other way, at the present time, could this need have been met.

Personal Appearance of the Staff Nurse

A New Discussion of an Old Question

AS long as public health nurses are women and individuals, the question of personal hygiene and personal appearance will probably be an ever-burning one. Here is the latest opinion on this subject from representative staff nurses in different parts of the country. While most of them feel that a certain amount of leeway should be allowed as to such details as style of uniform, use of rouge, etc., there is a general conviction that the nurse as a representative of a professional group and as a teacher of health should meet certain standards of dress and appearance.

Publicity in general is the art of interpreting the ideas of an organization to the public so that they will be understood. Individual publicity is far more widespread than perhaps many people realize. Advertising is one phase of publicity and the nurse in the field of public health is very active in this type of publicity although she may seldom think of it in this light. The uniform alone may be said to serve as a medium of advertising personal hygiene and its relation to health. We all admit there is something about the force of personality and personal appearance that carries far more conviction than any printed word.

Certain kinds of medical work can be accomplished only when the public coöperates. Health work of this type is the prevention of tuberculosis, infant, preschool and maternity supervision. It is important that the public be educated in the rules of hygiene, and who is more able to do this than the public health nurse, well groomed and showing evidence of actual application of the rules of personal hygiene. Many people are best reached through visual representation—life pictures rather than words!

Here are some replies. There are three important points about the uniform question:

(1) The question of personal appearance can perhaps be best and most easily handled on a large staff by the proper selection of staff nurses. If a wise and proper selection is made, apart from choosing the type of uniform to be worn, the matter of personal appearance can very well be left to the discretion of the staff nurses themselves.

(2) A standard uniform is by all means essential. We are all aware of the existence of individual differences as shown in likes and dislikes in style of dress. Therefore on a large staff where individuals are of various age groups, personality, temperament and social backgrounds, it is advisable for the Director to select perhaps two or three attractive styles suitable to almost any type of individual and then allow the nurses to choose the one they wish to wear.

(3) If cosmetics improve the appearance of the nurse they should be used judiciously. Omission of lipstick and red finger nail polish is advised. The public health nurse in uniform should always remember that an attractive and well dressed person is never extreme in her dress or make-up.

Winifred Devlin.

I have heard this criticism. "Wasn't she a splendid nurse, but how horrible she looked in that grey uniform!" There was the association of efficiency, overruled by a poor choice of color in dress. And truthfully, how can a red-haired nurse look well in a grey uniform? Does not navy blue suggest a more soothing color for that type of person? In my opinion, we are fast approaching the time when regulations as to color of uniforms must be made more flexible. Too many nurses forget that not only should clothes fit the person and the occasion, but also the times. Even now, when the well-fitted tailored waistline, so becoming to most figures has been worn for two years, many nurses are still wearing the loose-fitting uniform with the belt five inches below the waistline, because "we cannot afford to buy new ones when the old ones are still good."

Just as certain colors are suited to some individuals and not to others, so are cosmetics. Where cosmetics are necessary, they should be used with utmost care. What impression does Mary and Johnnie receive from the pale, hollow-eyed, tired nurse, who tells them that playing in the sunshine and fresh air will paint their cheeks from the inside? For the nurse who really needs cosmetics, I say, use them, for we must remember that the ideal of good health is our "message", and must stand out conspicuously at all times.

Flora Hanbery.

It has always been my opinion that a well groomed nurse, in full uniform, is an asset to any organization. She can do better work because her mind is not distracted by thoughts of soiled collar, or unkempt hair, run-down-at-the-heel shoes, etc. The well groomed nurse inspires confidence and creates faith in her ability to aid and advise her patients where the slovenly nurse would be looked upon with suspicion, her work being judged by her personal appearance. The staff nurse should try to appear as attractive as possible, and, in my opinion, if a little rouge and powder improve her appearance she should use them—in moderation.

The uniform of the staff nurse is her badge of authority. If the matter of personal hygiene and personal appearance is left to the individual there would be no uniformity, as among a group of nurses there will always be found one or two who will create a standard of their own. We are all familiar with the nurse who wears a different style shoe because it makes her foot look smaller, or a different color because it suits her complexion. So, considering these facts, the agency is justified in setting a standard, and expecting each staff nurse to meet this standard.

A Staff Nurse.

In communities where the nurse is working alone the question of personal appearance is the individual nurse's responsibility except that the community does expect her to be tidy. The nurse realizes from past experience that neatness is traditionally associated with the profession.

Unless the type of uniform is specified by the agency, it is left to the discretion of the nurse. Starched uniforms are difficult to care for, especially in the winter when coats are worn. Soft materials such as crepe de chine, silks, rajah cloth, either blue or grey, are preferable in that they require less laundering and this can be done with ease by the nurse if she so desires. Thus the initial expense of the silk uniform is made up in the lower laundry bills. The grey uniform, rather than the blue, is probably the public's choice. [Do any of our blue-frocked nurses wish to challenge this? *Ed.*] White collars and cuffs and a black tie with a train-

ing school or public health nursing badge are the accessories that help make a uniform and add to its attractiveness.

Stockings look best when they match the uniform or the shoes. Shoes should be approved, well-fitted, and comfortable. Comments among the school children have been often heard concerning the nurse that wears spiked heels on duty. The adolescent girls will imitate the nurse, especially if her appearance appeals to them. Practice what you preach is especially applicable here. Similarly, the teacher of dental hygiene will not get very far unless her own teeth are in perfect order.

To summarize some of the questions that may well be asked:

(1) Does the general appearance of the nurse indicate that she practices the health rules?
(2) Is she happy, and does she have a pleasing personality?
(3) Is her hair dressed in a becoming manner?
(4) Does she use cosmetics with discretion?
(5) Is her uniform neat and becoming?
(6) Does she wear the proper type of shoes?
(7) Is she well poised?
(8) Is she the type of woman that is a good example to influence the younger generation in thinking more of healthful living?

Hilkea Jacobs.

The question of the personal appearance of public health nurses usually resolves itself into one of uniforms. The uniform is, of course, a hangover of student nurse days. The hospital which serves as the so-called laboratory for nursing education requires for its personnel the kind of clothing which affords the greatest amount of protection to every one in an institution devoted to the care of the sick. The military system, extant in hospitals, is reflected in the requirement of uniforms for various types of personnel employed in various capacities.

For staff nurses of public health nursing organizations the uniform has been retained for several reasons, among them the following:

1. Protection of patient and nurse from infection, presumably in services involving bedside care of the sick. Washable clothing obviously affords this same protection. However, washability does not necessarily presuppose uniformity and uniforms are not indicated for these purposes in nursing services which do not involve care of the sick.

2. Identification of the nurse in the community for purposes of publicity for the organization which she represents. This type of exploitation of the staff nurse through her costume, no doubt picturesque, seems to me eminently unfair. The display of staff nurses in uniform for the purpose of attracting attention to the organization may have publicity value (witness the wide adoption of uniforms for their personnel by commercial firms for advertising purposes) but it is hard on the individual nurse to be so conspicuously labeled in public.

3. Protection of the staff nurse from personal harm. This has never seemed convincing to me since I have never known of any harm to other social service workers because of a lack of a uniform, although their work certainly carries them into equally "dangerous" situations. I have however heard objections from recipients of public health nursing services, to calls from health department nurses who came in full regalia including marked automobiles, thereby arousing the curiosity of the whole neighborhood.

4. Regulation of individual tastes in wearing apparel of staff nurses through the adoption of one style for all. It is quite true that what seems in good taste and appropriate to one may seem impossible to another—but, whose taste is to be considered in laying down an arbitrary rule? Clothing is one of the channels of self-expression most cultivated by all women and it seems to me an infringement upon individuality of expression to have to wear things not of one's own free choosing. And why should women of one profession have to spend most of their waking hours in a uniform any more than teachers, lawyers, social workers, etc., just because part of the period of preparation for one particular profession was spent in an institution which existed exclusively for the care of the sick and hence was justified in prescribing clothing which insured protection to patients and personnel? Doctors engaged in public health do not ever afterwards appear in uniforms just because they wore them as internes!

5. Another reason so often emphasized in inspirational letters to groups of nurses intended to promote *esprit de corps* among our ranks is pride of uniform. This type of *esprit de corps* which relies for strength upon such externals is pretty cheap and flimsy stuff as far as I am concerned—in the category of morale strengthened by flag-waving and band playing.

As one of those unpopular and difficult-to-manage persons known as individualists, I believe that women of my profession as well as those of other professions should be allowed to choose their own styles unless wearing uniforms can definitely be proved to have a positive effect upon our work as public health nurses. I protest exploitation of the uniform and the person who wears it for advertising purposes. The argument of protection of the nurse from personal harm and the well known saying "you ought to be proud to have the right to wear a uniform" are just so much sentimental "bunk" to me.

A Necessarily Anonymous Public Health Nurse.

The general public is daily becoming more "personal hygiene conscious" because of the widespread commercial advertising and special articles found in our current magazines and newspapers. Because of publicity sponsored by local and national health organizations and the accessibility of institutions such as clinics and hospitals, many communities have definitely become "health conscious". These facts have set a standard in the minds of the public which compel us to measure up to the standard expected of public health nurses.

People have come to recognize the public health nurse by her uniform. Who among us has not heard some child say, as we alight from a street car or drive up to the gate, "Mother, here comes the nurse"? Sometimes we are not known personally to the family but our service and uniform have told our story before we reached the home.

Unfortunately, although there is a more or less accepted standard to be attained in regard to personal hygiene and uniform appearance, we have among us some who are efficient in many ways but are seemingly careless in regard to such details. No staff supervisor would countenance a disregard of staff rules or unethical conduct on the part of a member of that staff without an ensuing consultation. Although we are ashamed to admit that such conditions exist, is not disregard of the accepted standard of personal hygiene or the prescribed uniform of vast importance and, therefore, in need of enforcement?

General appearance may provide the needed example for many an individual or family. It is so much easier to accept the health teachings of one who exemplifies these same teachings by being well groomed.

It would, therefore, seem that the appearance of the public health nurse is of considerable importance. The staff which employs her has every right to insist that her uniform and personal hygiene shall be of a quality to justify her working with that organization.

Leta Seaman.

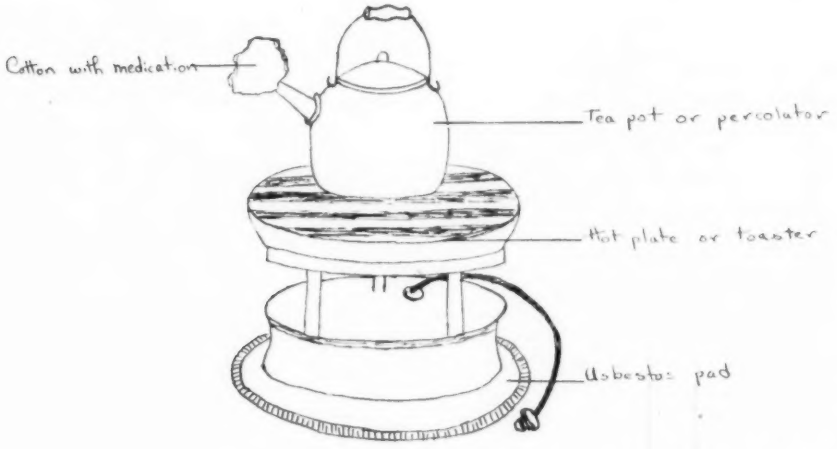
Improvised Equipment

From Elizabeth McGraw, Supervisor, Cleveland, (O.) Visiting Nurse Association:

The public health nurse has an excellent opportunity to apply her skill in improvising. In the hospital she is so accustomed to having everything at her finger tips that it takes a little time to discover the unusual resources to be found in the kitchen cupboard, on the basement shelf or in the "Five and Ten".

In the observation district of the Cleveland Visiting Nurse Association there is a cupboard containing many trays of improvised equipment assembled to help the new nurse to teach in the home, and to give adequate care with what she usually finds on the family shelves.

In giving an eye, ear, or throat irrigation a Mason jar with rubber tubing and connecting tube can be used. (See picture.) This equipment is easily sterilized. In giving hot fomentations, a stewing kettle with a collander can be used and kept steaming on a hot plate. An ordinary wire basket, used for draining dishes, can be used for assembling the baby clothes.



—*Drawn by L. Weyrick.*

Steam Inhalation

ARTICLES NEEDED	METHOD
Asbestos pad	Place near bedside
Percolator or teapot (metal)	Fill teapot with water
Hot plate or toaster	Insert cotton into spout of teapot
Rx and cotton	Sprinkle Rx on cotton
	Direct toward patient

The following equipment can be used for giving a douche as well as for other kinds of irrigations—

ARTICLES NEEDED

Mason jar with can rubber

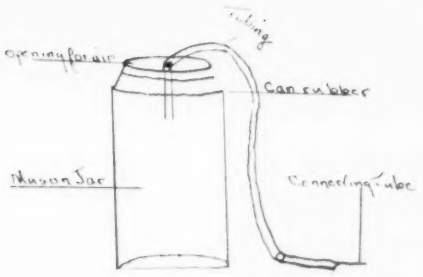
Rubber tubing

Glass connecting tube or medicine dropper

Make an opening in top of cover into which a rubber tube is inserted.

A small second opening must be made in the top of the cover for air.

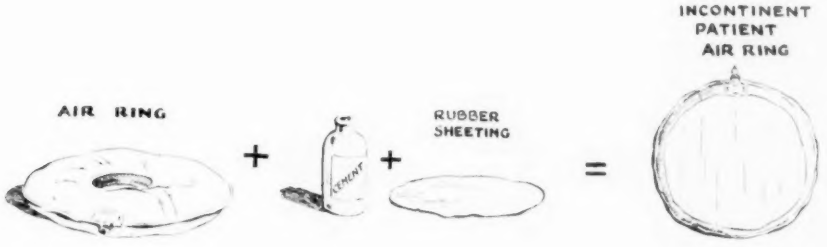
On the free end of the rubber tubing, insert glass connecting tube or medicine dropper.



Irrigating Equipment

From Mary McConnell, Assistant Supervisor, Philadelphia, (Pa.) Visiting Nurse Society:

The accompanying illustrations show how a satisfactory arrangement can be made with a rubber air ring to care for an incontinent patient.



Cement a piece of rubber sheeting, cut to measure, to the bottom of an air ring so that a pocket is made in the center of the ring. When in position, the ring prevents the patient from developing bed sores and greatly facilitates nursing care. Small squares of old linen can be used to cover the ring, changed as frequently as needed. While the ring must be removed at regular intervals for cleansing, this can be done with small discomfort to the patient. The bed is kept dry and the laundry is reduced. A small pillow at the back of the ring under the patient's back adds comfort.

Our Own Reader's Digest

The Rôle of Emotion in Tuberculosis*

By MARY B. EYRE, R.N.

Professor of Psychology, Scripps and Claremont Colleges, Claremont, California

THE human organism responds as a whole to its internal and external environment. When we conceive of it thus, we need not separate mind and body (much less "soul" and "body"), but regard the human individual as trying to get along with the use of all of his functions, all his endowment, all his learning and experience.

Because he is a human being, his functions include not only his feelings, but the use of his brain. Stirred-up feeling is known as emotion, and implicit in emotion is *energy*, which is always dynamic. The individual who experiences emotion is therefore *ready to act*. The researches of Professor Cannon have demonstrated that the sympathetic division of the autonomic nervous system, through the adrenal glands (and possibly other tissues), prepares the body for activity at the same time that the individual is under emotional stress. If the discharge of this energy should not take place, then the preparatory processes become disturbers and disrupters of the organism.

For the tuberculosis patient, this disturbance is especially severe, because he cannot work it off, or by change of locale shift his interest to another scene. Hence in tuberculosis, emotion devastates the organism to a greater degree than with a well and mobile individual.

Again, tuberculosis is a disease in which emotional strains are inevitably brought about in family and business relationships, through the long duration of the illness, the enforced break in family ties and obligations, and the financial strain. Segregation usually emphasizes these factors, and the patient has at the same time leisure for brooding, thus causing undue distortion of his problems.

Every patient with tuberculosis has, therefore, *ipso facto*, his emotional problem. In the case of patients who are in state and county institutions, this is exaggerated by loss of funds and consequent feeling of humiliation at "having to come on charity."

Whatever pet theories we may entertain as to motives for mental conflicts, it is a practical fact that each one of us needs at least to feel safe, if he is to give his best to the business in hand. Anything which menaces our bodily, mental, or financial security, sets up at once a state of tension, which disintegrates our assembled forces in fronting our world. In the weak and timid person, he who has never learned self-reliance or known what it means to think well of himself by reason of success due to his own efforts, *the sense of his inadequacy* is always his first response. To tell him "not to worry" and to "control his emotions," far from helping, usually increases his tension without showing him how to release it. Something detrimental does happen to all responses of the individual, through worry; something beneficial takes place as inevitably through the building up of the sense of security.

Of all the emotions, fear seems to be the predominating one. The characteristic optimism which is generally attributed to tuberculosis was found in a number of observed tuberculous patients to be compensatory to an underlying fear and dread

* Reprinted from the Transactions of the Twenty-eighth Annual Meeting of the National Tuberculosis Association, 1932, and excerpted here. This paper has been published in full in the *American Review of Tuberculosis*.

of non-recovery, which they resolutely refused to admit to themselves or to acknowledge to others.

If optimism, and like traits, are inherent symptoms of tuberculosis, it would be necessary to posit the specific toxin of tubercle bacillus as the cause of the hopeful state; this state is more simply explainable by the defense mechanism aroused by fear, superimposed upon the general biological stimulation which is the body's reaction against this bacillus.

It would seem reasonable to ask of any measures which set out to regulate emotion, that they should prove their validity by producing an effect upon the general bodily well-being of the patient.

Such an attempt was undertaken during the summers of 1929-30, at the Los Angeles County Sanatorium, California, having at that time 755 patients. Reports have been previously made. Eighty-seven patients were under observation. Although a complete comparison with physical symptoms was not made, it would be possible to check the records of emotional behavior with the extensive and accurately kept physical histories. The net results of this study were in terms of social adjustment.

It was decided to deal only with those whose chances of recovery or arrest were at least tentative; and the following questions were posited for answer:

1. Is the emotional instability of tuberculosis patients due entirely to toxemia?
2. Is lack of progress in the patient's condition traceable to emotional causes such as fear, etc.? If so, which predominates?
3. What benefit can mental hygiene bring to patients as to:
   (a) physical improvement?
   (b) mental placidity?
   (c) increase of ability to become self-supporting?
4. Are patients who give vent to their emotional conflicts more amenable to treatment than those who repress emotion but brood in secret?

Fear was the chief factor in emotional instability. It was found to be present, to some detectable extent, in all but two instances. One of these was a patient who had been told that as "a light case" she would be ready to go home, as soon as she recovered from an appendectomy which had brought her to the acute unit. Her attitude was quietly relaxed, without tension of any sort, either of marked cheerfulness, stoicism, or depression. It was almost startling to find a patient who felt no need of any form of defense against fear.

Outlets must satisfy the inmost aspirations of the individual, and carry on his energy in channels appropriated to his needs. It is not enough merely to tell him to "work off" his excess emotion. It must be used creatively after his heart's desire, in some fashion. A young man in college who was suffering emotionally, exclaimed: "I took a long hike, hoping to walk it off, but I came back feeling worse than when I started out."

Dr. Cannon points the way physiologically, by showing the disrupting effects upon an organism prepared by emotion for violent action, if the physical action be deferred or prevented. He stops at that point. The principle can be carried further, to provide adequate means by which the excited organism *can* find use for the energy which it is prepared to expend, through interests fitted to its intellectual level. This becomes an individual problem.

Much has been written on the control of emotion and on its harmful effects in tuberculosis. To warn a patient against giving way to his feelings, without showing him how to bring about this control, is but to increase his strain; just as to beg him when in great bodily fear, "not to be afraid," usually augments his terror.

Re-education of the patient, in the sense of helping him to understand the sources of his emotional stresses in order that he may know how to re-route their component energy, is the most practical therapeutic aid for the emotional problems of tuberculosis. The individual must first be helped to face his difficulties, and to

identify the feeling-habits in himself (usually dating back over long periods) which led to his failure; he must be shown how to substitute new feeling-habits, which will lead to better adjustment; how to rely upon himself, and become emotionally grown up; and finally, how to find adequate constructive outlets for his emotional energy. In bed patients, these outlets must necessarily be through mental instead of physical channels.

Impressions of a Russian Clinic

It has been very difficult to secure much information on public health in Russia—a subject of unfailing interest to every one just now. We take pleasure, therefore, in quoting from the *South African Nursing Record** the impressions of a British nurse who paid a visit to Leningrad last summer—*Editorial Note.*

"The shortage of food in Russia is the constant cry of the English newspapers. To be perfectly frank, the people in the streets of Leningrad do *not* look half starved, their physique actually compares very favorably with any industrial area in Britain. Old men and women were scarce. The old women we did see could be correctly described as 'hags'. It would be interesting to know what has become of the majority of the old people. Are they placed in suitable homes or did they perish in the great famine a few years ago?

One afternoon we visited a new clinic. It is claimed that three thousand mothers and children are treated here weekly. The outline of this scheme is good, the detail leaves much to be desired. In the main hall the records are kept. They were untidy and had a dog-eared look. The entrance for patients has been planned with skill. Small rooms, made partly of glass, by which means the patient can be seen as she enters, connect with similar rooms with nothing but basins of running water in them. The order is this: the patient comes into the outer room, the attendant sees her and notifies the examining doctor; the doctor enters the inner room, washes his or her hands (there are many female doctors in Russia), and passes into the room with the mother and baby; nothing is in this outer room but a table and mackintosh (rubber sheet) and one calico cover; the patient is examined and history noted; mother and baby are then placed in another small white room opposite the consulting room of their particular specialist, and not more than five or six people are ever placed in each room, so that very little waiting occurs. In this way from the moment a patient arrives she is isolated, and if there is anything infectious she cannot transfer it by sitting for a long period in a crowded waiting room, with dozens of others, who themselves may be suffering from any complaint under the sun.

Bathrooms were frequent and though not elaborate were clean and the arrangements practicable. X-ray apparatus was large and the equipment looked very similar to ours. The dispensary lacked that neat spick and span appearance, with which we are familiar. The same could be said of the laboratory, where we saw a few members of that enemy of hospitals—the house fly.

A well fitted up massage and light department completed the scheme, which, when it takes on the thoroughness and attention to detail which it ought to have, should accomplish an incalculable amount of good for the community.

The few nurses we saw wore white coats, clean and rather badly ironed with very little or no starch and the usual white handkerchief of the peasant on the head. From under these caps peered round, healthy young faces, glancing at us with that mixture of shyness and self-confidence which makes the type familiar in hospitals the world over.

It will be worth noting, as time goes on, if Russia puts the word 'thoroughness' into her campaign for advancement."

*February, 1933.

"Come, Come, Come to the Fair"

By DOROTHY J. CARTER

Assistant Director, National Organization for Public Health Nursing

TO GO or not to go to the Century of Progress is a question that many are propounding to themselves this summer. To be sure there is much there that one can well get along without seeing—the usual "ballyhoo" of the Midway—but on the other hand, there is so much that is worth seeing that any one who has an opportunity to go should not lightly turn it down.

It is difficult to decide whether the general effect of the settings and buildings is more striking in the broad daylight with its exhilarating impression of color and space, or at night when all that modern illumination can do transforms land and water into a fairyland of lights and shimmering reflections. And whether one likes modernistic architecture or not, no one can deny that the general effect is absolutely unique.

The buildings that seem to hold one the longest are those grouped around the south lagoon, the Hall of Science, the Hall of Social Sciences, the Electrical, Radio and Communication Buildings; and in these buildings, particularly in the first two, are those exhibits of special interest to public health nurses.

DON'T MISS THESE!

The section on Social Welfare to which every good community worker will turn, is in the Hall of Social Sciences. The section is divided into small rooms or booths each portraying some phase of social welfare. The first thing that impresses one is the fact that practically nowhere is the name of any one agency or group to be seen—no local advertising of services—but the entire emphasis placed on the needs of the community and the way modern social service meets those needs. One of the larger rooms, for instance, is divided in two, one part showing "Individualized Care," which includes child guidance, and care of the handicapped and mentally ill; while the other side emphasizes "Family Service," contrasting the old method of alms-giving with the modern method of family case work.

Practically all of the exhibits, by the way, are in the form of dioramas (three dimension exhibits) or illuminated panels or pictures—all excellently done and extremely effective. What captions or explanations there are, are short and telling, and each service so simply and clearly portrayed that even the most "unknowing" of laymen must catch the meaning, even if he loiters for only a moment.

In one corner of the booth on "Social Aspects of Health", one finds five small dioramas portraying the public health nurse in the role of the visiting nurse, the rural nurse, the nurse in industry, the frontier nurse and the school nurse. "The children always recognize the school nurse," said Mrs. Garland Thomas, who is on hand to answer questions and who used to be a public health nurse herself. Over the small dioramas is a balopticon with fifty slides showing different kinds of nursing activities from the day the student nurse enters the school to the time when she becomes a leader of nursing. Also in that booth are portrayed maternity and child care and hospital social service.

Another booth is devoted to the "Constructive Use of Leisure" portraying group activities, handicraft and creative arts, and "the fourth 'R' in Education—Recreation", showing a modern school playground and model back yards with play equipment.

One of the cases in the exhibit of the National Council of Women is of particular interest to the nursing field,

showing the Red Cross flag that floated from the masthead of the relief ship bearing Clara Barton to the Mississippi flood, Linda Richards' pin and diploma from the New England Hospital for Women and Children, a model of the Henry Street Settlement playground and a photograph of Lillian D. Wald.

AN EDUCATION IN ITSELF!

Across the bridge from the Hall of Social Science is the imposing Hall of Science with its immense outside Court of Honor and Great Hall inside. Here one literally could spend days and receive a liberal education. On the ground floor devoted to the medical and allied sciences is the excellent exhibit of the American Medical Association emphasizing the periodic health examination, medical education and progress in health education. The American College of Surgeons shows some vivid dioramas portraying hospital care "then and now."

Here, too, one finds the exhibits of the research laboratories including the Institut Pasteur, and the various drug manufacturers. One company transported a mediaeval apothecary's shop from the other side of the water, including the old mortar and pestle and the immense seal of permission from the Crown "to make and sell 'Life Pills' for plague, poison and all human ailments."

Upstairs are the well planned exhibits of the Illinois State Health Department and other local and national groups.

Nurses will want to see, too, the incubator baby concession, manned by the entire staff of nurses of the Premature Baby Department of Michael Reese Hospital.

Across the lagoon there is the Enchanted Island, a sort of glorified playground for children conducted by the Junior League, where children may be parked for the entire day. Before the child can be admitted to the playground it passes through the Health Ship where a physician gives it a once-over for rash and other suspicious symptoms.

AND MORE AND MORE

But one does not want to spend all one's time at the professional exhibits—there are too many others leading one on—the Gutenberg Press brought over from Germany upon which Johannes Gutenberg printed many of the early books, the Belgian village complete with market place and moat; the Transportation Building showing the development of travel from the old covered wagon to the most modern of railway express trains and aeroplanes; the motor car buildings where one can see an automobile being put together and learn, at last, what really happens when one shifts the gears and puts on the brakes; the model homes built and furnished in modernistic style; the electrical building—a fascinating place—with exhibits ranging all the way from the most complete housekeeping appliances to the awe-inspiring high voltage machines; and last—one of the best of all—for those who love art, a perfectly stunning international exhibit of painting and sculpture in the Art Museum, ranging from early Italian to modern French, where one could spend hours and still not be satisfied!

To be sure, the Fair can become a little wearing if one tries to take it too strenuously; one needs a discriminating eye and a comfortable pair of old shoes! As one visitor has said "it is a combination of vivid coloring, extraordinary, unusual buildings, truly scientific, well-planned exhibits and boardwalk at Atlantic City"; and to this writer's thinking, at least, the buildings and exhibits far outweigh the boardwalk.

CONTRIBUTORS PAGE

ISABEL GLOVER BACHELS, R.N. (Mrs. Andrew) is a graduate of the University of Colorado School of Nursing, Boulder, Colo. She has had wide experience in public health nursing, the last position held before her marriage being as director of Child Health Service in the Denver Tuberculosis Society. Mrs. Bachels' story of her experiences certainly testifies to the truth of the statement—once a public health nurse, always a public health nurse!

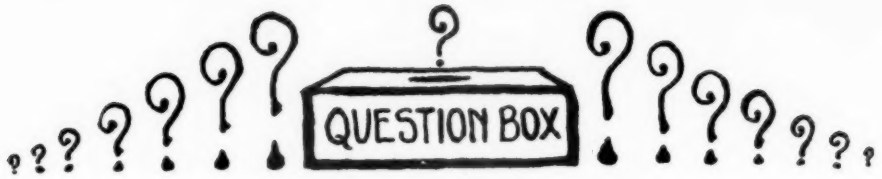
DR. C. W. STILES, who contributes the article on hookworm disease, is a resident of Winter Park, Florida, and Washington, D. C. Since his retirement from the U. S. Public Health Service three years ago because of ill health, he gives a considerable part of his time to volunteer public health work in the South. He is part-time member of the faculties of Rollins College and of Johns Hopkins University. He has served our Government for forty years on active duty, has represented this country since 1895 on the International Commission of Zoological Nomenclature, and is a member of many American and foreign medical and scientific societies, including the French Academy of Medicine.

Most of Dr. Stiles' studies have been in the southern States, where in 1902 he recognized the American hookworm as a new species and determined the widespread prevalence of the disease it causes. Later he induced Mr. Rockefeller to offer one million dollars to be used toward the control of the malady and he served for five years as scientific secretary to the Rockefeller Commission.

EMMA RAE McLEOD, R.N., is a graduate of Lockwood Hospital, Petoskey, Michigan. She has had experience in private duty; in the Victorian Order of Nurses; industrial nursing, (Michigan); overseas service and public health nursing in the United States, including courses at Teachers College, Columbia University, and experience on the Henry Street Visiting Nurse staff, New York City. She is at present Director of the New Brunswick (N. J.) Visiting Nurse Association.

MRS. MARGARET B. WRIGHT, who collaborates with Miss McLeod in writing this article on prenatal service, is a graduate of Vassar College and is publicity chairman of the New Brunswick (N. J.) Visiting Nurse Association Board.

The Hall of Science—"A Century of Progress."



QUESTION:

What are some of the *large* public health nursing agencies, supported by private funds, doing about the problem of relief-giving by the staff nurses?*

ANSWER:

[To answer this, we wrote to several large private agencies in the East, Midwest, West, and South. Their answers follow]

"The depression has not changed our policy in regard to relief-giving by the staff. Very occasionally the nurse may have to provide emergency food if the first visit to the patient is made very late in the day and the relief agencies are closed. As soon as the nurse realizes a relief need, she calls the Social Service Exchange to find out if any agency has at any time been interested in the case. The family is referred to the agency which knows it, or, if never known to a relief agency, the nurse selects the one that most easily will fill the need. Thereafter the nurse and relief agency naturally work together, but at no time do any of our nurses act as the agents for a relief organization."

"We do not give relief of any kind. We have a Social Service Consultant on the staff, who is a public health nurse with experience in public health nursing, and who later prepared herself for the social service field and has been a hospital social service worker, as well as a worker in family relief agencies. While her job with us has nothing whatever to do with the giving of relief, we do find that she has been of great assistance during this depression period. Of course, our reason for placing her on the staff was not to fill the emergency needs of the depression, but largely to help with the educational program of our staff nurses and, also, to handle cases on which we were obliged to make an initial visit but which really did not need the service of a visiting nurse. When she makes the first visit on a case that sounds problematical when it is reported to us, and she finds that it is a case for a relief agency or some other social agency, the case is referred at once. If she finds it is a case for hospitalization, she makes the necessary arrangements. Since we have a great many of this kind of case coming to us, it conserves the time of the staff nurses for their real job. We feel that our consultant's services are of inestimable value. I am convinced that a nurse with adequate background and preparation for this kind of program would be a great asset in any public health nursing organization."

"Our organization is firm in its policy that relief-giving should be done by relief-giving agencies, and not become a part of the work of the visiting nurse. This does not mean that our group of nurses are not helping, as they see signs of need, but they manage it by clearing the family with the Social Service Exchange, and then reporting the needy case to the right source of help among our various relief-giving agencies. We have no trouble in this cooperation, and only when these agencies are out of funds, have we tried to interest individuals in giving help. Such procedure is only followed after consulting the agency on the case.

We have always had a supply of layettes to be used for the new born babies of our needy cases. We are the media for giving out these layettes, although no Visiting Nurse Association funds are used for the garments. This may be considered an exception to our rule of no relief-giving. In most cases, it is possible to send some member of the family, usually the unemployed father, to our office for the layette.

We believe our nurses have a definite part to play in their service to the community by confining their efforts to the profession of nursing. Even 'a little giving' of cod liver oil, milk, or clothes starts something that is hard to check, and once it gains impetus, it detracts from the nursing service, to say nothing of duplicating or upsetting plans made by the social worker on the case."

"Probably the greatest extravagance in agency administration is duplication and the consequent confusion of effort due to the lack of clearly defined objectives and the steady adherence to these objectives. In a great crisis it may be wise to make even radical changes in objectives, but the temptation to do something about desperate situations too frequently leads to pottering and loss of direction.

*We refer our readers in rural work to Miss Stewart's article in our July number for a description of how the relief problem has been handled by some rural nurses. The rural situation is, of course, quite different from the urban where there are always community relief resources at hand.

Based on this principle, this association has always adhered to the policy of not giving material relief and over a period of years has found it possible to practically eliminate the giving of even surgical supplies. This, of course, is due to the fact that social agencies giving relief are ready and willing to coöperate with the nurses wherever practical—and are managing their jobs as effectively as the nurses think they are their own. Therefore in this emergency, objectives have not changed and only a slight adjustment in policy has been made. An unsolicited fund, comparatively negligible, (a few thousand) has been made available. The plan for use of this fund has been approved by the relief agencies and hence there is no confusion or duplication. It has been used almost exclusively in supplementing diet in families on public relief and eliminates the necessity of another agency making a social investigation when the need represents only addition to diet. (The social problem—unemployment—is not easily solved by any agency.) While this plan is the result of the gift rather than a fund sought by the plan, it has worked most satisfactorily and economically for all concerned.

A small fund known as a 'Comfort Fund' has always been available for very slight services falling within this definition and for unusual emergencies."

QUESTION:

Should public health nurses be expected to solicit funds or sell chances at parties to raise money for the organization expenses when there is an executive and a nursing committee?

ANSWER:

Securing the money for the administration of the nursing service in voluntary agencies is the responsibility of the board of directors and its appropriate officers and committees. The NOPHN *Board Members' Manual* states:* "The executive director and the nursing staff should not be asked to take part in soliciting funds."

Mary S. Gardner in *Public Health Nursing* states:† "The nurse's own freedom from the weight of financial responsibility should be carefully guarded. She cannot do justice to her work if in addition to it any such burden is laid upon her. She may rightly be expected to present the work publicly when asked to do so and can always at the same time make a statement of the financial situation. Such talks, however, are in the long run more effective if made for the purpose of educating the audience to an understanding of public health nursing than when given for purposes of solicitation."

The NOPHN agrees with the policies expressed in these quotations.

*Page 14.

†Page 98.

QUESTION:

"How is it possible to check an income restriction for patients using a well-baby clinic if there is no social worker to investigate the patients' statements and no social service exchange through which to clear the case?

ANSWER:

It is assumed that by "no social worker" is meant no agency doing family case work. If the territory covered by the clinic service is not too extensive, the nurses' knowledge of the financial status of families familiar to her will be sufficient information for this group. For new families, the nurse will have to judge from their statement as to the probabilities of their being able to pay for a private doctor. Later home visits should make it possible for her to verify this decision. It is assumed, of course, that the patient has no connection with a private physician whose opinion can be sought.

NEWS NOTES

Every one will heartily commend the awards given by the Social Work Publicity Council for outstanding contributions to social work interpretation in 1932-33. First on the list is *The Survey Graphic,* which quite outstripped its already high reputation this past year, particularly in the two special issues, December, 1932, featuring the report of the Committee on the Costs of Medical Care; and January, 1933, featuring the Study of Social Trends.

Next in line stands the Birmingham, Alabama, Health Department for its frank and courageous appeal for continued appropriations for the health program as sounded in the monthly bulletin, *Birmingham's Health.*

The Woman's Crusade of the Cincinnati Community Chest campaign, the Chicago Council of Social Agencies *News Letter,* and the news releases on the Boys' Club Study of the New York City Welfare Council, were also given awards.

✣

The Association of Community Chests and Councils has changed its name to Community Chests and Councils, Inc. John Stewart Bryan, formerly director of the Richmond, Virginia, Community Chest, is the newly elected President.

✣

Miss Evelyn Davis, assistant director of the N.O.P.H.N., has been elected Chairman of the National Committee on Volunteers in Social Work. The objects of this group are:

To draw volunteers and board members into the National Conference of Social Work

To help volunteers understand their relationship to professional social work

To create an awareness among the professional group of the importance of the volunteers' contribution to social work

To assist the professional group in fostering a closer relationship with volunteers.

✣

Statistics may be boring at times but here are some impressive figures from the 1932 Summer Round-Up conducted by the National Congress of Parents and Teachers.

Children entering school in Fall	165,503
Children receiving examination	84,925
Parents or guardians present	67,889
Defects discovered	134,591
Defects corrected	40,065
Children vaccinated for smallpox	30,021
Children immunized for diphtheria	21,894

✣

As a memorial to Lena K. Schmidt, former director of the Madison (Wis.) Public Health Nursing Association, who met her death so tragically this Spring, the Association is raising money for a permanent cod liver oil fund to be used for needy children in Madison. Miss Schmidt started the fund in 1931.

✣

The Michigan Board of Registration of Nurses will hold an examination September 12-13 for graduate nurses, September 12 for trained attendants, at the Peter White Library, Marquette. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than August 28. Mrs. Ellen L. Stahlnecker, R.N., Secretary.

✣

Mrs. Josephine Jokaitis, R.N., at present on the staff of the Metropolitan Life Insurance Company in Chicago, was asked to present "Nursing" to the first Congress of Polish Women, meeting in Chicago in July. Mrs. Jokaitis worked in Poland after the World War under the American Red Cross.

✣

Twenty-nine interested organizations in Australia met recently in Melbourne to make plans for organizing a College of Nursing at the University of Melbourne to prepare graduate nurses for administrative and supervisory positions.